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AN ASSESSMENT OF THE INTEGRATION OF THE MENTAL HEALTH COMPONENT INTO THE CARE OF WOMEN AFFECTED BY INTIMATE PARTNER VIOLENCE IN PERU

By

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SUMMARY (ENGLISH)

Violence against women (VAW) is a public health problem and a human rights violation. It is highly prevalent in Latin America and the Caribbean; the Multi-country Study on Violence against Women by the World Health Organization identified rural Peruvian women as suffering the highest rates of VAW. The country is party to CEDAW and Belen Do Para Conventions, which set forth recommendations to overcome this form of discrimination and describe the role of the health sector. Peruvian law defines violence as a mental health issue. Objective: The Ministry of Health's three technical guidelines were reviewed to assess the integration of mental health into the care of women affected by violence Method: The protection of the woman's mental health was ascertained in the conventions mentioned above. The recognition of the mental health consequences of VAW and the inclusion of its evaluation and care were assessed in pertinent Peruvian legislation. Using these international and national parameters, the three guidelines for the attention of violence were subject to content analysis to see whether they conform to the conventions and integrate mental health care. Outcome: These guidelines are too extensive and do not clearly define the responsibility of health workers. They do not include a mental health exam in the evaluation of the victim and are vague in the description of the actions to be carried out by the health care provider. Guidelines prescribe universal screening using an outdated instrument and moreover, WHO Guidelines do not recommend screening. Conclusion: These multiple guidelines do not provide useful guidance for health care providers, particularly for the assessment of mental health sequelae, and unnecessarily stigmatize survivors of violence as mentally ill. It is recommended that the World Health Organization's document *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (2013) be used as a blueprint for only one technical instrument that incorporates evidence -based national policy and guidelines.

KEYWORDS:

Gender based violence, legislation, health sector, practice guidelines, spouse violence-prevention and control, women's health services

RESUMEN (ESPAÑOL)

La violencia contra las mujeres (VCM) es un problema de salud pública y una violación de los derechos humanos. Tiene una alta prevalencia en América Latina y el Caribe, el Estudio Multipaís de Violencia contra las Mujeres de la Organización Mundial de la Salud identificó que las mujeres peruanas sufren la más alta tasa de violencia. El país es signatario de CEDAW y de la Convención de Belen Do Pará que tienen recomendaciones para enfrentar esta forma de discriminación y describen el rol del sector salud. La ley peruana define a la violencia como un problema de salud mental. Objetivo: Se revisan las tres guías de práctica clínica del Ministerio de Salud para ver la integración del componente salud mental en la atención de las mujeres afectadas por VCM. Método: se evaluó la protección de la salud mental en las convenciones mencionadas. Se revisó la ley peruana pertinente para ver el reconocimiento de las consecuencias de la VCM sobre la salud mental y su atención. Usando estos parámetros nacionales e internacionales, se realizó un análisis de contenido de las guías peruanas para la atención de la violencia para ver cómo integran la salud mental. Resultado: Las guías son demasiado extensas y no definen bien la responsabilidad del prestador de salud, no incluyen el examen mental en la evaluación de la víctima y son vagas en la descripción de las actividades que debe llevar a cabo el proveedor. Se recomienda el tamizaje universal con formato antiguo y de difícil manejo. Conclusión: Esta múltiples guías no dan adecuada orientación al trabajador de salud, particularmente para la evaluación de la afectación de la salud mental, e innecesariamente marcan a las mujeres sobrevivientes de VCM como enfermas mentales. Se recomienda que la reciente Guía de la OMS *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (2013) se use como molde para la elaboración de un único instrumento técnico que incorpore la política nacional y lineamientos basados en la evidencia.

PALABRAS CLAVE: violencia basada en género, legislación, sector sanitario, guías prácticas, violencia conyugal- prevención y control, servicios de salud para las mujeres

RESUMO (PORTUGUESE)

A violência contra as mulheres (VCM) é um problema de saúde pública e uma violação dos direitos humanos. Ele tem uma alta prevalência na América Latina e no Caribe; o Estudo da Violência Contra as Mulheres da Organização Mundial de Saúde (OMS) identificou que as mulheres peruanas sofrem o maior índice de violência. O Perú é signatário da CEDAW e da Convenção de Belém do Pará, com recomendações para resolver este tipo de discriminação e descrever o papel do setor da saúde. A lei peruana define a violência como um problema de saúde mental. Objectivos: As três orientações clínicas do Ministério da Saúde para avaliar a integração da componente de saúde mental no cuidado de mulheres afetadas pela VCM foram revistas. Método: A proteção da saúde mental foi avaliada nas orientações acima mencionadas. A lei peruana relevante para perceber o reconhecimento das consequências de VCM na saúde mental e os cuidados prestados neste contexto foram revistos. Usando esses padrões nacionais e internacionais, foi realizada uma análise de conteúdo dos guias peruanos para a atenção da violência para ver como eles se integram a saúde mental. Resultados: Estas orientações são muito extensas e não definem claramente a responsabilidade dos profissionais de saúde. Não incluem um exame de saúde mental na avaliação da vítima e são vagas na descrição das atividades a serem realizadas pelo prestador dos cuidados de saúde. As orientações recomendam uma triagem universal usando um instrumento com formato antiquado e pesado. Em contrapartida, as orientações da OMS não recomendam qualquer triagem. Conclusão: As várias orientações analisadas não fornecem a informação necessária para o profissional de saúde avaliar o envolvimento da saúde mental e, desnecessariamente, tratam as mulheres sobreviventes de VCM como doentes mentais. Recomenda-se que as orientações recentes da OMS (*Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013*) para os cuidados de VCM sejam usadas como um modelo para o desenvolvimento de um único dispositivo técnico que incorpora directrizes com base científica.

Palavras-chave: legislação com base no género, saúde, guias, prevenção e controle da violência conjugal, cuidados de saúde para as mulheres

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INTRODUCTION

The United Nations defined Violence against women (1993)[1] as: “any act that results or is likely to result in physical, psychological or sexual harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in private or public life”. This definition includes all forms of violence against women during the entire life cycle, from selective abortion of female fetuses, to the different forms of abuse against girls and adolescents, violence perpetrated by husbands and other relatives all the way to elderly abuse. There are many types of potential perpetrators

Gender-based violence (GBV) is “violence that is directed against a woman because she is a woman or that affects women disproportionately”, [2] and his definition underlines that the subordination of women lies at the foundation of GBV.

Domestic violence (DV) is "Any incident or pattern of incidents of controlling, coercive or threatening behavior, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. Intimate partner violence (IPV), on the other hand, describes physical, sexual or psychological harm by a *former or current partner or spouse*. [3] This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional”[4]. Controlling and coercive behavior, physical assault leading to injuries and even death and sexual abuse such as rape and demanding unwanted degrading sexual acts are forms of IPV. IPV is a specific, frequent manifestation of GBV, and I will refer to IPV in this paper, unless otherwise noted.

IPV is considered a public health problem due to the documented long lasting and severe effects on human health, which include fatal outcomes, acute and chronic injuries and disabilities, serious mental health problems and behavioral changes that increase the risk of further victimization and gynecological diseases, unwanted pregnancies, obstetric complications and HIV/AIDS[5].

Gender based violence as a public health and human rights issue

The conceptualization of gender based violence (GBV) as a public health problem started around 1977, with efforts at defining the problem, such as the concept offered by Walker of a "battered wife syndrome",[6] as well as research aimed at estimating the prevalence of violence using a classical epidemiological perspective. The demonstration of widespread violence against women prompted recommended responses from governments and international organizations.

A second stage in the public health approach to violence has followed a socio- medical perspective with the search for understanding the social and cultural determinants of violence and the response from the health sector, including barriers to disclosure and access to services.[7] Medical anthropology and sociology have helped identify cultural factors in the health providing professions that account for lack of incorporation of knowledge into practice guidelines and everyday practice. They have also seen GBV as an expression of male power over women, which is reinforced by culture and religion.

Violence against women, especially IPV, has enormous consequences in terms of mortality (directly in homicide, and indirectly through suicide, maternal causes and AIDS) and morbidity (physical and mental), economic costs and broader social costs, in terms of perpetuating poverty because it keeps women from participation in the work force and it impairs efforts to improve women's access to education. The attainment of the Millennium Development Goals 3 (promote gender equality and empower women), 4 (reduce child mortality), 5 (improve maternal health) and 6 (combat HIV/AIDS and other diseases) depends on the full participation of women. This cannot happen if women are fearful of violence. [8]

On the other hand, the recognition of GVB as a human rights problem[9] stems from the development of the concept of violence as a form of discrimination and the challenge of "androcentrism" as the paradigm for ethical values.

The Declaration of Human Rights[10] enshrines the right to "life, liberty and security of the person" (art 3), "freedom from slavery and servitude" (art 4) and from "torture and from cruel, inhuman and degrading treatment" (art 5) for "everyone without distinction of any kind such as race, colour, sex…" (art 2)

The Organization of American States adopted in 1994 the Inter American Convention on the Prevention, Punishment and Eradication of Violence against women (Convention do Belem do Para)[11] which is the first international instrument defending women from all forms of violence. This treaty has had the most ratifications in the Americas. It states in its Preamble that violence against women "is a manifestation of the historically unequal power relations between women and men", and recognizes that the right of every woman to be free from violence includes the right to be free from all forms of discrimination.

United Nations General Assembly adopted the Convention on the Elimination of all forms of Discrimination against Women[12] on 18 December 1979. It entered into force as an international treaty on 3 September 1981 after the twentieth country had ratified it. "The spirit of the Convention is rooted in the goals of the United Nations: to reaffirm faith in fundamental human rights, in the dignity, and worth of the human person, in the equal rights of men and women."[13]

The Convention starts by expressing concern about the persistence of discrimination against women despite extensive work and documents reaffirming the principle of equality. It devotes substantial space to civil and political rights, as they are indispensable to establish respect for the liberty, dignity and self-determination and for the political participation of women. The Convention also enshrines sexual and reproductive rights and the right of women to health services.

The right to health has been further defined in General Recommendation 24 (20th session, 1999)[14], which defines the conditions in which women are able to exert their right to health. It includes (para 6) women with mental problems among those who need special considerations. It makes an appeal for states members to take special measures to protect women with mental disabilities, of risks to mental health to which women are disproportionately susceptible because of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation (para 25).

The impact of violence on the enjoyment of rights by women is discussed in General Recommendation 19,[15] which states that violence is a serious form of discrimination[16]. In paragraph 6, it includes the mental dimension of violence, in paragraph 7 it mentions "The right to the highest standard attainable of physical and mental health" among the rights to which women are entitled. In para 11, the impact of violence on physical and mental health is described as the mechanism by which violence keeps women from enjoying and

exercising their rights. Both forced abortion and sterilization as well as family violence are cited as affecting mental health (para 22 and 23).

The Declaration on the Elimination of Violence against Women[17] considers in its Preamble that violence against women is a manifestation of unequal power relationships between men and women and a violation of women's human rights. Article 3 contains examples of these rights, such as the right to life, the right to equality, the right to the highest standard attainable of physical and mental health, or the right not to be subjected to torture, or other inhuman or degrading treatment or punishment.

LITERATURE REVIEW

I reviewed relevant World Health Organization and Pan American Health Organization documents about IPV. I conducted a search in PubMed for "Violence against women consequences" and "violence against women interventions" in Pubmed and Redalycs (Open access to the world scientific production in Ibero-American journals) for "violencia contra las mujeres" and looked at the relevant articles published after 2000. This review endeavors to assess the magnitude of the problem, to understand the emotional and physical consequences of IPV on women's health and to spot models of intervention to guide the assessment of the Peruvian technical practice guidelines.

Dimension of the problem

The scientific investigation of the problem of violence against women inside the house, as in IPV, is relatively new, arising from the realization, in the second half of the 20th century that GBV is a serious threat to the health and human rights of women.

The determination of the prevalence of IPV, the "hidden crime",[18] is challenging due to social and individual factors. Individual factors, among others, are the fear of the perpetrator's reaction, especially if the woman has to continue living with him, lack of confidence in the police and the judiciary, economic of emotional dependence on the perpetrator, reluctance to admit the failure in the relationship, and shame for what is perceived as a personal shortcoming.[19] Social factors are social tolerance for violence, lack of social and familial support, and difficulties in getting the attention of the relevant health or law enforcement officer to identify the difficulties experienced by the victim.[20]

However, in the past 20 years or so, there has been progress in measuring the extent of this problem as awareness of the problem has prompted research, particularly multi-centric population based studies. Estimates on the prevalence of IPV vary greatly from study to study, and this was explained in terms of differences in the definitions, methodology, interviewers training and other aspects of the research itself, besides actual differences in the occurrence of IPV.

The Multi-country Study on Women's Health and Domestic Violence against Women, initiated by WHO in 1997 endeavored to study the prevalence of IPV using a uniform methodology in order to obtain reliable information. It was carried out in 10 countries,

(Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania) where 24000 women, from 15 different sites were interviewed following strict ethical and technical guidelines. [21] ,[22]

The proportion of women who reported having ever suffered from physical violence by a current or former intimate partner varied from 13% in Japan to 61% in Cusco, a province in Peru[23]. 59% women in Ethiopia and 6% in Japan reported sexual violence. The most common form of physical violence was slapping, followed by hitting with a fist. Severe violence occurred to 4% of women in Japan and 49% of women in Cusco. In most countries a woman had a greater likelihood of experiencing severe than moderate violence, except in Bangladesh, Japan and Serbia and Montenegro.

In general, women reported that violent acts were not isolated, but rather a continuous experience; the vast majority of women who has experienced a violent act in the past 12 months had done so at least once every month, except for extremely violent acts, such as choking.

The proportion of women forced into intercourse ranged from 4% in Serbia and Montenegro to 46% in Bangladesh and Ethiopia. In Peru 11% of women had to perform sexual acts that they found humiliating or degrading, this happened to less than 2% of women in Tanzania and in Serbia and Montenegro. There was an overlap of 30% of sexual and physical violence overall.

The wide variations observed from region to region, in spite of the uniform methods of collecting and processing the information, supported the theory that risk and protection factors in an ecological model (including individual, partner, and contextual factors) may explain the occurrence of violence in a given case, beyond what we already know about age, partnership status and education:

Age: younger women (aged 15-19) are at higher risk (41%) of current violence (i.e. in the past 12 months) than women aged 45-49 (8%).

Partnership status: divorced or separated women have a higher risk of violence. Women cohabiting have higher risk than married women do.

Education: a higher degree of education seems protective against IPV; although in some countries (urban Brazil, Namibia, Peru, Thailand, and the United Republic of

Tanzania), this protective effect appears only if the woman has higher than secondary education.

The publication of this report marked a four-fold increase in the number of studies on the prevalence of IPV. Nowadays, information is lacking only from certain areas in Africa and the Middle East.[24]

A valuable source of data about IPV is the Demographic and Health Surveys, which started collecting this information in the early 90's, based on the Conflict Tactics Scale. Later on, experts developed a module to collect information on "domestic violence" that can be used in different settings with some adaptation. The countries have included this progressively. Peru, for instance, started collecting the information in 2000. The DHS Questionnaire collects information on age, marital status, parity, contraceptive use, education, employment, and empowerment status, for women aged 15-49, as well as their husband's education, occupation, and alcohol consumption. Women's attributes combined with the reported attributes of their husbands provide the characteristics of marital unions. The analysis of this information has allowed Kishor and Johnston[25] to report on the prevalence of IPV in nine countries (Cambodia, Colombia, Dominican Republic, Egypt, Haiti, India, Nicaragua, Peru and Zambia). Highest prevalences are reported in Zambia, Colombia and Peru (48, 44 and 42%) and the lowest in Cambodia, India and Dominican Republic (18, 19 and 22% respectively).

Some of the common risk factors identified are having more than one marriage, or being currently divorced or separated, younger age at first marriage or union, a larger number of children and being older than the husband/ partner. In some countries- such as Perú - urban residence poses a higher risk. The wealth of the family does not have a linear relationship with the risk of suffering violence; that the husband frequently comes home drunk does. Having a family history of IPV seems to raise the odds of violence for both husbands and wives. Women who believe that wife beating is justified in certain circumstance have higher risk of experiencing violence. Being accused of unfaithfulness (the jealousy of a husband) is linked to a significant higher risk of violence, as is the controlling behavior of the husband.

In Cambodia. Colombia, India and Nicaragua there is a negative linear relationship between years of education and violence risk. In Egypt, Peru, Dominican Republic and Zambia the least risk is linked to secondary and superior education and the highest risk to primary education. In Haiti, the higher the education level, the higher the risk. In

Colombia, the Dominican Republic, Haiti, India, Nicaragua and Peru women who are currently employed and making cash report more violence than unemployed women do.
Among the characteristics of the men, education has, in general, a negative monotonic relationship with perpetrating violence, except in Peru, Haiti and Zambia. In Cambodia, Dominican Republic and Haiti the man's occupational status does not influence the risk of violence. In Nicaragua, Peru and Zambia non-agricultural occupation seems related to more violence, In Egypt, India and Colombia the women whose husbands are in non-agricultural occupations experience less violence, but the differential is small.
The relationship between the experience of violence by wives and the frequency of drunkenness among men who consume alcohol is positive, monotonic, and highly significant in all countries where data on drunkenness are available (Cambodia, Dominican Republic, Nicaragua, Peru)
PAHO researchers have looked at prevalence and characteristics of IPV in Latin American and the Caribbean[26] analyzing data from DHS and Reproductive Health Surveys (RHS) that were nationally representative, gathering data on VAW, population based with face-to-face interviews, collected data between 2003 and 2009 and were the most recent for the given country. Thirteen studies comprise the report: Bolivia 2003, Bolivia 2008, Colombia 2005, Peru 2007/8, Ecuador 2004, Nicaragua 2006/7, Nicaragua 2008/9, Honduras 2005/6, El Salvador 2008, Paraguay 2008, Jamaica 2008/9, Dominican Republic 2007, Haiti 2005/6.
Physical violence ever is most prevalent in Colombia (38.6), Peru (38.6) and Bolivia (52.3). The countries with the lowest prevalence are Dominican Republic (16.1), Jamaica (17) and Haiti (13.4).
Sexual violence ever is most prevalent in Bolivia (15.2), Nicaragua (13.1) and Guatemala (12.3); it is least prevalent in Dominican Republic (5.2), Jamaica (7.6) and Paraguay (8.9).
The woman's characteristics related to violence were urban residence, younger age (15-19), except in Peru and Dominican republic, where more violence appeared at 20-24; the prevalence for IPV was lowest for women in the highest quintile of wealth, but the relationship is not linear, with highest risk reported in the second and third quintiles. Likewise, education did not have a linear relationship with violence, as was also noted in Kishor's report. Women who had more than one marriage, those cohabiting and women who were divorced or separated had higher risk.
Except in Nicaragua, the risk of violence ever was higher for women currently employed.

Speaking a language other than Spanish at home, (that is to be identified as having a minority ethnic origin) was linked to a lower risk of violence in the countries reporting: Paraguay, Guatemala and Peru.

A recent WHO publication that examines existing data on violence against women (VAW) shows that

- The global lifetime prevalence of physical and sexual intimate partner violence (IPV) in ever-partnered women is 30% (95% confidence interval 27.8 – 32.25%)
- Prevalence varies from region to region, with the highest prevalence in Africa, Eastern Mediterranean and South East Asia (around 37%), the second highest prevalence rates are in the Americas (30%), and the lowest in high-income countries and European and Western pacific regions (25%)
- Women aged 40-44 show the highest prevalence (37.8%; 95% CI 30.7 – 44.9%), but even those aged 15-19 show high rates (29.4%; 95% CI 26.8 to 32.1%)
- Sexual violence by non-partner is also quite frequent, with a global lifetime prevalence of 7.2 (95% CI 5.3 – 9.1%)[27]

Effects of GBV on physical and mental health

Abuse of women and girls by intimate partners has several well-recognized effects on health; some are direct as the result of the trauma and others are indirect, as the result of exposure to chronic stress.[28] Even though women who have been abused use health services more often than those who haven't, they often do not present with obvious trauma, but rather manifest diverse forms of physical and psychological symptoms and report lower quality of life. [29]

There have been many descriptions of the dynamics involved in violence against women. The earlier literature described a three-stage cycle: tension building, active battering and the honeymoon stage that repeated itself and often escalated in severity. This cycle provokes in the woman psychological responses that go from denial to guilt, enlightenment and finally responsibility. In the first two stages, the woman seems to accept violence as the consequence of her own shortcomings. In the last two stages, she may take action either to end the violence or to leave the relationship. These cognitive and emotional changes will determine whether the woman chooses to preserve her relationship or to preserve her self. [30]

Women's responses to violence are variable, and so are the consequences on her mental health. These involve a series of potential psychological and physical symptoms and disorders. The impact of intimate partner victimization is determined by a series of factors: the direct effect of the violent experience, the characteristics of the victim herself, (such as history of previous trauma, her reactivity, and pre-existing psychiatric morbidity) and the social and cultural context (social disempowerment, poverty, lack of support and stigmatization) in which the violence occurs.[31]

Approximately half of the women abused by their partner sustain injuries that merit help seeking[32]. Twenty to 35% of women attending emergency rooms in the USA have injuries related to experiences of GBV. [33] These injuries include black eyes, dental injuries, broken bones, bruises, cuts and concussions. Chronic headaches, abdominal pain, muscle pain, recurrent vaginal infections, sleep disorders and disfigurement, gastrointestinal symptoms and disorders, recurring central nervous symptoms such as fainting and seizures, and neurological sequelae of head trauma and choking, are among the chronic physical consequences.

Severe physical injuries are predicted by length of relationship abuse and severity of violence, with a tendency for stalking and psychological abuse to predict PTSD[34]. The largest health difference between battered and not battered women is the frequency of gynecological problems: sexually - transmitted diseases, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, and pain on intercourse, chronic pelvic pain, and urinary-tract infections. These conditions affect victimized women in general, not only those sexually abused. There is also a relationship with higher rates of HIV/AIDS and unwanted pregnancy, probably accountable for by sexually degrading and controlling behaviors, such as refusing to use condoms and interdiction of contraception. Abuse interacts with complex social, cultural and psychological factors involved in decisions and actions to prevent sexually transmitted diseases and unplanned pregnancies[35]

There is some evidence that VAW is linked to delayed diseases such as hypertension, arthritis, insulin dependent diabetes and heart disease.[36] These indirect health consequences may be due to changes in neuro-endocrine function[37] and authors estimate that stress accounts for 80% of the indirect effect of abuse on women's physical health. [38]

The effects on mental health are severe: depression, anxiety and post-traumatic stress disorder are the most prevalent,[39] and they are frequently comorbid; but suicidality, eating disorders, substance abuse, psychosis, personality disorders, low self-esteem and poor social function are also reported.[40]

About one quarter of victimized women, attending primary health care settings, are diagnosed with depression. When different forms of violence (physical, sexual and psychological) violence coexist, the risk of presenting depressive disorders is increased fivefold. In the meta-analysis performed by Golding, [41] the prevalence of mental health problems in women exposed to violence by an intimate partner was 47. 6%, in 18 studies of depression (OR 3.80 (3.16–4.57), 17.9 % in 13 studies of suicidality, 63.8% in 11 studies of post-traumatic stress disorder, 18.5% in10 studies of alcohol abuse and 8.9% in four studies of drug use. Nolen Hoeksema [42]and Beydoun[43] have argued that about one third of depressive disorders and elevated depressive symptoms in women can be attributed to previous experiences of intimate partner violence.

About half of women who have experienced severe physical or sexual violence present with comorbid depression and PTSD[44]. These are more likely to describe concomitant psychological abuse and to display more severe depressive symptoms, less adaptive behaviors and coping strategies. The presence of depression is predicted by the severity of physical or sexual abuse and by the occurrence of psychological abuse. Suicidal ideation happens in relation to psychological abuse with more frequency.[45]

The severity of injuries, stalking and psychological abuse[46] are factors that seem to predict the presentation of PTSD.

According to the meta-analysis by Beydoun et al[47] of clinical and community samples of pregnant and non-pregnant women, the odds of major depressive disorder (MDD) were 3.26 times higher in women exposed to IPV than in those not exposed. Elevated depressive symptoms (EDS) associated with IPV were between 4.5 and 1.85, and the odds for postpartum depression (PPD) were between 1.40 and 5.38 higher in women exposed to IPV. They conclude that a sizable proportion of MDD, EDS and PPD may be attributable to IPV exposure.

Substance use, particularly alcohol, is involved in two ways in violence against women: it is an important facilitator of men's, but not women's, perpetration of violence [48]and there is evidence of an association between experiencing IPV and drinking in women.

Affected women may use alcohol to cope with the consequences of ongoing violence; but, conversely, women's use of alcohol may trigger abuse from men, as they may think that women should not drink. Indeed, longitudinal studies show a bidirectional association between alcohol and violence: There is a positive association between women's experience of intimate partner violence and subsequent alcohol use, as well as an association between alcohol use and subsequent intimate partner violence. [49]

Suicide is one fatal outcome of exposure to VAW. The World Health Organization Multi country Study of Violence against Women and its Effects on Health shows a definite association of suicidal ideation and attempts and intimate violence experiences. In this study 20967 women of reproductive age in 13 rural and urban sites in ten countries - Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia, Thailand and Tanzania- were surveyed by uniformly trained interviewers using a standard instrument. The prevalence of lifetime suicide attempts ranged from 0.8% in Tanzania to 12% in Peru, suicidal thoughts ranged from 7.2% in Tanzania to 29.0% in Peru (rural). In the past four weeks, suicidal ideation varied from 1.9% in Serbia to 13.6% in Peru (rural) with intimate partner violence being the most consistent risk factor. [50]

Pathways of Health Effects of Violence

Physical trauma, psychological trauma, stress, fear, and control contribute to the health effects of intimate partner violence through a series of complex interactions , which may lead to the final adverse health outcomes of disability and premature death (homicide, suicide, other cause).

Physical trauma causes musculoskeletal, soft tissue and/or genital injuries that may lead to disability and low quality of life and at the same time may increase mental health disorders. Stress and psychological trauma cause damage to mental health: PTSD, depression, anxiety, eating disorders and suicidality occur in violence victims. Substance abuse may also appear in this context, alone or comorbid with mental health conditions.

Long term exposure to stress, as well as unattended symptoms of depression and anxiety together with substance (alcohol, tobacco, illegal substances, anxiolytics) abuse may also lead to chronic non communicable conditions (hypertension, diabetes, cardiovascular disease) and to psychosomatic conditions such as irritable bowel syndrome, chronic pain, and chronic genital pain.

Fear and control contribute to the emotional and behavioral symptoms and disorders mentioned, at the same time, they influence help seeking behavior and limit sexual and reproductive control. These two aspects may condition perinatal morbidity (low birth weight, prematurity and pregnancy loss) and impinge on sexual and reproductive health (unwanted pregnancy, abortion, HIV/AIDS, other STD's and gynecological problems).

Physical and psychological trauma and exposure to fear and control may lead to adverse mental health outcomes and/or substance abuse independently or in combination. These are central to the increase in health risk posed by violence, although premature death and disability can occur, as well, without mental health impairment.[51]

Violence against women in Latin America and the Caribbean (LAC)

Demographic and health surveys (DHS) as well as reproductive health surveys (RHS) have been carried out originally to gather data on demographic and reproductive issues; since 1990 DHS started asking questions about violence and since 1995 these questions have been included in RHS. These have evolved into modules that have recently incorporated what was learned in the WHO Multi Country Study (MCS) although they were initially based on the Conflict Tactics Scale. Nowadays these modules ask about prevalence, type of violence, specific acts, what triggers the violence, physical and emotional consequences and help seeking behavior.[52]

The Pan American Health Organization has recently released an analytical report on the results of these modules, from 2003 to 2009, which shows that violence is highly prevalent in the region, though prevalence varies from setting to setting. It has been reported as 17% in the Dominican Republic 2007 and as high as 53% in Bolivia 2003.[53]

In our region, the intensity of the violence varies from occasional kicks and blows to consistent, long-term maltreatment, known as "battering". Emotional abuse and controlling behaviors are also very common in the region; however, controlling behaviors are consistently more frequent in women who experience the most physical and sexual violence. There are different socio-demographic factors linked to intimate partner violence, but the impact of these varies from country to country; remarkably, violence is not more prevalent among those women with the least education and material resources.[54]

More than two-thirds (69.9%) of women in Bolivia 2008 and more than three-fourths (77.9%) of women in Guatemala 2008/9 who experienced partner violence in the past 12

months reported anxiety or depression as result of the violence. Nearly half (49.6%) of women in Colombia 2005 who experienced partner violence ever reported feelings of worthlessness as a result. [55]

Large proportions of women from Paraguay, Salvador, Ecuador, Nicaragua and Guatemala who experienced partner violence in the past 12 months reported anxiety or depression so severe, as a result of their partner's aggression, that they could not complete their work or other obligations. This was reported by nearly one-half (49.0%) of women in Ecuador 2004 to more than two thirds (68.5%) of women in Paraguay 2008. In Bolivia, 75.5% of women report they live in constant fear of more aggression.

Large numbers of women, both in the DHS/RHS as in the MCS have reported suicidal ideation. Devries et all have looked at the link between violence and suicide in the MCS samples and they report that the prevalence of lifetime suicide attempts ranged from 0.8% (Tanzania) to 12.0% (Peru city); lifetime thoughts of suicide from 7.2% (Tanzania province) to 29.0% (Peru province), and thoughts in the past four weeks from 1.9% (Serbia) to 13.6% (Peru province). The most consistent risk factors (after adjusting for common mental disorders) for suicidal ideation risk in this population were intimate partner violence, non-partner physical violence, ever being divorced, separated or widowed, childhood sexual abuse and having a mother who had experienced intimate partner violence.[56]

Violence against women as a priority issue in Peru

The WHO multi country study [57](MCS) has shown the high prevalence of violence against women, severe violence, sexual violence, suicidal ideation and physical illnesses in urban (Lima) and rural (Cusco) settings in Peru. Among ever-partnered women, 49% in Lima and 61% in Cusco reported lifetime physical violence. 46.6% of women in Cusco and 22.5% in Lima reported sexual violence ever. Half the women who had experienced violence reported injuries, but the percentage of those who had suffered severe lesions was higher in Cusco.

In Lima, 15% of women ever pregnant reported physical violence during pregnancy. This experience was reported by 28% of ever-pregnant women in Cusco. One in ten women in the sample referred sexual abuse perpetrated by men other that the intimate partner. Women who reported physical or sexual violence were twice as likely to report "poor health". [58]

Demographic and Health Surveys (DHS) in Peru ask about intimate partner violence since 2000. According to the DHS 2007-8, 38.6% women reported physical violence by a partner ever; in Lima the figure was 37.3 (v 48.6 in MCS) and in Cusco, 46.2 (v 61.0 in MCS). These wide variations have been explained by PAHO in terms of:

- the data being gathered in different years (2000 v 2007-8),
- the fact that DHS is a national sample and MCS was included only two subnational samples,
- MCS had a broader definition of "intimate partner" to include boyfriends and lovers,
- DHS measured violence by most recent or current partner only,
- the foci of the studies were different, MCS was geared only to the study of violence, so all resources were invested in asking about it, and the wording of the questionnaire was different, especially about sexual violence, which was more broadly defined in MCS.[59]

Miranda and Diaz have estimated[60] that the lost productivity due to violence against women in Peru is about 7 thousand million dollars (in 2007).

Around 70% of all complaints filed to the police in Peru in the year 2007 were about familial violence. In 90% of the cases, a woman was the victim.

Seven percent of research projects on violence in Peru deal with mental health.[61] Fifty one percent of women up to one year postpartum surveyed in a public hospital in Lima in 2007 had been victims of physical violence; they were five times as likely to develop postpartum depression as those who had not experienced violence.[62](Escobar Montalvo 2008, quoted by MIMP 2006)

Current research in Peru points out that mental health is more severely affected by sexual violence: Reynaga studied women who had been victims of political violence in Ayacucho and found that, in their perception, the scars left by sexual violence have been the most difficult to overcome.[63] Qualitative research shows that sexual violence victims are "more impulsive and have fragile egos" (Lecca 2009 quoted by MIMP 2006, p 121)[64] Zorozabal found a correlation between sexual violence and sexual dysfunction in a group of 182 women. [65]

According to the recent PAHO analysis of Demographic Health Surveys, violence against women in Peru is more prevalent in urban women, with 7 to 11 years of education, aged 30 – 39, in the third and fourth wealth quintiles and currently employed. Women who are separated or divorced, those who have had more unions, have 5 or more children, and were partnered before 15 years of age are also at higher risk.[66]

"Physical and sexual violence ever" was higher in Spanish speaking women than in indigenous women (defined as those who speak another language at home), a finding common to other LAC countries.

The Office of the Ombudsman (OOP) regularly supervises services for sexual and reproductive health, including services for women affected by violence because violence has such a great impact on a woman's health and wellbeing. This is done to fulfill the OOP's obligation to protect the rights of especially vulnerable populations, i.e. women, who may see their fundamental rights affected by omission or wrong application of the regulations by the state's agents. In the supervision carried out in 2009 and published in 2010,[67] the findings were that only 22.7% of establishments fulfilled current Minister of Health regulations regarding register of women affected by violence, and only about 46% of the personnel had received pertinent training. This leads to low rates of meaningful attention to victims, where 41% of providers look only at physical lesions, about a third do not collect specimens for identification of perpetrator in cases of sexual violence and only and 5% refer the woman to psychological services, even though sedatives are prescribed by 32.3% of providers in cases of sexual violence.[68]

Particularly worrisome is that few providers pay attention to the mental health impact of violence: 45.8% of providers give physical and mental care, while 42.4% only provide physical care and 11.9% only mental care. A full third of those supervised revealed they only do counselling and referral.

The role of the health sector in the response to violence

Although most women do not tell anyone that they are suffering from IPV, the fact that they suffer from injuries and diverse symptoms related to the abuse brings them into contact with health providers with frequency. (See above) This means that the health sector is in a privileged position to respond to the needs of these women, ideally in the

context of a systemic approach, due to the complexity of violence, involving factors at the individual, relationship, community and society level.[69]

The systemic approach involves changes in countrywide policies, laws and protocols; infrastructure changes in health establishments to insure privacy and confidentiality, training of all staff, strengthening of referral networks and availability of services for sexual violence victims (PEP, EC etc.)[70]

The United Nations Entity for Gender Equality and the Empowerment of Women (UNWomen) has reviewed the theoretical models that are useful in building a comprehensive response form the health sector[71].

The ecological model describes

> Individual factors (such as gender, past history of violence, education, employment),
>
> Relationship factors (parental conflict, conjugal conflict, association with friends who are violent, friction over women's empowerment, etc.)
>
> Factors in the community (high unemployment, high population density, lack of information, social isolation of women, weak community, traditional gender roles) and
>
> Societal factors (poverty, inequalities, tolerance for violence, impunity, no legal rights for the victim, etc.)

This model allows the identification of factors that primary prevention should address, in order to decrease the prevalence of violence. It is also useful in challenging the restrictive biomedical approaches because it calls attention to the multitude of factors that need to change, many of which are outside the influence of the health sector.

The multisectoral framework, on the other hand, highlights the responsibilities exclusive to the different sectors involved in a coordinated community response. In this model, the community is served by and participates in the actions coordinated by a central authority that coordinates the participation of the legal/justice systems, the police and security forces, the psychosocial resources, the health sector, NGO's and other civil society organizations under clear, consensual Guiding Principles. In this paradigm, the health sectors is cognizant of the other sectors participation, and has specific responsibilities:

To train providers to recognize and address violence against women and girls,

To insure same sex interviewers for persons who have suffered sexual violence

To respond to the immediate health needs of the women or girls exposed to violence, including safety planning

To institute protocols for treatment, referral and documentation that insure confidentiality

To provide free of cost violence - related services and

To provide forensic evidence and testimony in court when authorized by the individual

In this approach, there are some cross cutting issues: education to the community, safe and confidential data collection, intra-and inter-sectorial coordination and the creation of reporting and referral networks. These must be carried out in a coordinated effort, by all sectors.

Decker et al [72] have discussed the systems model from the perspective of implementation science. The theory calls for examination of policy (does the intervention offer a viable solution for the problem of IPV?), the people involved (for instance is the administration leadership supportive of IPV interventions?) and the context (the system to assist women who screen positive for IPV in case screening is implemented). The Kaiser Permanente model, designed to make use of the entire healthcare environment, facilitate change in clinical practice by "making the right thing easier to do" and integrate IPV services in everyday practice, provides a paradigm for examination of the components of a functional systems model intervention.

The model includes

- leadership and oversight fully committed to services for IPV survivors, led by a physician champion in each facility,
- an inquiry and referral component (direct inquiry by clinician, prompts for inquiry in electronic medical records, posters to prompt discussion of IPV, materials for patients to consult IPV services),

- an on-site IPV services component (danger assessment, safety plan, triage to mental health and other specialized services, referral, support services, advocacy, employee support services),
- a supportive environment component (posters, leaflets, in waiting areas, resource cards in restrooms, website information, radio, TV and newspapers, well informed and trained staff), and
- Community-linkages (24-hour hotline, emergency housing, transitional housing, legal services, support groups for victims, children's services, batterers' groups).

The role of the providers is limited and clearly defined: **ask, affirm, assess, document and refer**. The tools in the EMR assist the clinicians in this task and the robust community links ensure access to crisis services and advocacy.

In order to provide significant services in a systems approach, the health services must develop resources and skills to assume the key responsibilities within and across the services. These key responsibilities are: [73]

To strengthen the institutional commitment to address IPV

To collaborate with other organization actively addressing it

To strengthen confidentiality and privacy through changes in infrastructure and processes

To improve the health workers' understanding of local and national laws about GBV and IPV

To improve providers' knowledge, attitudes and skills through sensitization and training

To strengthen referral networks and improve access to services

To develop or improve institutional protocols and practice guidelines

To ensure the provision of emergency services and supplies

To insure/improve the availability of educational materials for survivors of IPV

To strengthen medical records and information systems to enable staff to document and monitor individual cases

To ensure adequate monitoring and evaluation of GBV.

The "integration" of violence related services refers to the incorporation of activities in targeted providers (emergency, mental health, sexual and reproductive health) to insure that survivors presenting there will receive the necessary assistance, related to their experience of violence, as quickly as possible.

This integration may happen at the "provider level", where the provider has the skills to take care of all the different needs of the survivor. It may be at the "facility-level" where a range of services is available in the same institution, but not from the same provider. "System-level integration" is when a facility with integrated services also has a referral network, so the survivor can access different services in the community.[74]

The general principles that guide the health sector involvement are the adoption of a human rights centered and gender responsive approach, operating under ethical guidelines, employing cultural appropriate measures, responding to diversity, operating within an ecological model, responding to different forms and settings, working in partnership, ensuring a survivor-centered and empowering approach, and using evidence.

Although there is some controversy, the most recent evidence seems to point out that universal screening is not useful. The foremost concerns in the response to women's needs are ensuring the safety of the woman and responding to her specific health needs.

The sensitization and training of providers must take into account issues of gender and power within the health system itself and the fact that many providers have been abused at some point in their lives.[75]

Within these general frameworks, several models of intervention have evolved, mostly in developed countries, with a dearth of evidence about successful interventions in lower and middle-income countries.

Colombini, Mayhew and Watts have reviewed five intervention programs in Latin America, three in Asia and one in Africa, [76] finding that reproductive health services are the most frequent door of entry for abused women to access services, both at the primary and secondary level. Reproductive health clients are screened for violence and a series of services exist for them at the primary care facilities of the IPPF clinics in Latin America (Plafam in Venezuela and Inppares in Peru); for legal, shelter and other services, these facilities have a network of referral centers in the community. Selective integration in Honduras provides counselling and mental health services to clinic clients, without

referrals. In Malaysia, Bangladesh, Namibia and Thailand the One Stop Crisis Centre (OSCC) model provides comprehensive integration, where multiple services are provided in one facility.

The OSCC model, reported by Colombini et al[77] consists of a series of services in Accident and Emergency Departments of hospitals, offering round the clock, patient-centered services for abused women and children in one site, with the potential benefit of geographical closeness to all services, no delay, ease of referral to specialized and non-health services. The model includes medical care, counselling, police and social services. Internal referrals provide access to different medical specialties as needed, and external referrals connect with police, shelters and other services and NGO's. As the model has been extended to all hospital in Malaysia and to other South East Asia countries, several interrelated challenges have become apparent.

The lack of priority of violence in Malaysian health law, and limitations in internal and external coordination regarding IPV with limited inter- ministerial coordination, explain why facilities lack training on IPV and specific protocols. This in turn accounts for the lack of knowledge on IPV of the providers and their confusion when dealing with these cases, which in turn results in an inefficient use of time. Low priority of IPV also results in scarce monitoring and poor collaboration with other sectors, so that the successful experience in some Kuala Lumpur hospitals is not easily scaled –up to the rest of the country.

In Uganda the SASA! Project is an example of a community mobilization program to address violence against women, building on a social adaptation of the Stages of Change Theory. The outcomes will be changes in the acceptability of a woman setting limits to men's behavior, and the decrease of women's exposure to sexual violence. [78]

The Population Council has systematized the response to GBV in African countries[79]. The lessons learned in Zambia, South Africa, Kenya, Malawi, Zimbabwe, Ethiopia and Senegal from 2006 -2009 during the implementation of a multisectorial comprehensive model to strengthen responses to survivors of violence, especially sexual violence can be used as a resource for planning in other LMIC.

These lessons include the fact that violence affects adults and children, and that although most survivors are female, boys seek care as well. Guidelines are necessary, but they are

not enough to insure good services; however, the process of preparing the guidelines can spur inter-sectorial collaboration.

Regarding health services, the research shows that several models are feasible, and integrated services can improve quality and timeliness of the response, simple interventions can increase the delivery of emergency contraception after sexual assault. It is remarkable that provider capacity is an important barrier to quality comprehensive care and the requirement that forensic evidence is collected during the first consultation can get in the way of the survivors access to justice and quality healthcare. One problem is that hospitals and health centers may lack the necessary infrastructure to collect the evidence correctly. A more important factor is the requirement that a physician collect the samples, in locations where gynecologists are not available this means referring the victim to a higher lever facility with the corresponding delay. Overburdened staff and the possibility of corruption further complicate this issue. One of the responses has been to train nurses to perform forensic exams in settings where there isn't a doctor. [80]

Provider capacity is very important issue in LMIC: both the shortage of professional health care providers and the gaps in training make it daunting for IPV and sexual violence survivors to get the quality of care they need. Cross-sectorial training, which can improve the linkage between the police and the health sector, is one of the strategies tried in Africa: in Zambia and Malawi police officers, magistrates and health personnel participated in a two-day training course aimed at improving coordination among service providers through an enhanced understanding of their responsibilities and duties. They participated then in "customer care", with an emphasis on the importance of prophylaxis for STD and pregnancy. The presence of high- ranking police officers and health providers was crucial to demonstrate the authorities' commitment to the program, and to dispel misconceptions.

The Pan American health Organization has led the response in Latin America and the Caribbean, and has collaborated with WHO in the production of the landmark guidelines "Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines" that emphasize integration of training and health care for IPV survivors. The expert review of evidence-based interventions identifies key elements of good healthcare. These allow the guidelines to set forth six recommendations:

1. Woman-centered care: privacy and confidentiality, empathy, non-judgmental attitude, linkage to other services
2. Identification and care for survivors of IPV: inquire in cases when assessing conditions that may be caused or complicated by IPV in order to improve diagnosis and subsequent care
3. Clinical care for survivors of sexual violence: offer comprehensive care, first line support, complete examination, STD, HIV and pregnancy prophylaxis, documentation to determine when interventions are appropriate
4. Training of health care providers should be offered at the undergraduate, pre-certification level
5. Health care policy and provision, care should be integrated as much as possible with other services
6. Mandatory reporting of IPV and sexual violence not recommended

Notably, universal screening is no longer recommended, due to the ethical and pragmatic considerations that arise from the current literature.

OBJECTIVES

1. To identify the specific inclusion of recommendations pertaining mental health in the Convention of Belen do Para and the corresponding sections of the Convention on the Elimination of all Forms of Discrimination against Women
2. To assess the integration of the mental health component in the legislation regarding the care of women affected by intimate partner violence in Peru: the General Health Law, the Law Against Violence (Unified Text), Norms and Procedures For the Prevention and Attention of Family Violence and Child Maltreatment, the Practice Guidelines on Sexual and Reproductive Care, and National Guidelines for the Attention of Persons Affected by Gender Based Violence
3. To assess the implementation of Peruvian national guidelines which integrate the mental health component at the regional level

STUDY DESIGN

This is not experimental research but rather a critical reading of current international and national documents regarding mental health and the care of women affected by IPV in order to spot the inconsistencies and make recommendations to improve the interventions of the health sector in Peru.

Dependent variable: specific incorporation of mental health in Peruvian technical standards for the care of persons affected by violence in the health sector

Independent variable: inclusion of the mental health component in the Ministry of Health practice guidelines for the care of persons affected by violence

MATERIAL AND METHODS

For Specific objective 1:

The "Inter American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belen do Para)"[81] and the "Convention on the Elimination of all Forms of Violence against Women (CEDAW)"[82] with General Recommendations 19 (Violence against women) and 24 (the right to health)[83] were subject to content analysis to determine whether their protection extends to mental health.

Specific recommendations on the recognition and attention to mental health problems became parameters for the next step

For Specific objective 2:

The General Health Law of Peru[84], the Law against Violence[85] and the National Plan against Violence[86] were subject to content analysis to examine the inclusion of the mental health component.

Specific mentions of mental health became parameters for the next steps.

The three normative documents from the ministry of health were subject to content analysis to see if the mental health component is integrated and if they conform to the key recommendations of *Improving the Health Sector Response to Gender Based Violence, A Resource manual for Health Professionals in Developing Countries*[87]. (This document was a standard for the development of the health sector response before the advent of WHO Guidelines, 2013)

Content analysis measures

For CEDAW and Belem do Para Convention:

- Two measures: a general information one, that includes year approved, year ratified by Peru, monitoring body, and the scope (population included); and a specific one looking for allusions to health and mental health which includes:

  Explicit recognition of the right to health

  Explicit recognition of the right to mental health

Recognition of the consequences of violence on mental health

The role of the health sector

Mental health services

For Peruvian legislation (General Health Law, Unified text of the law for protection against family violence 26260 and National Plan for Violence against Women)

- Mentions to psychological/emotional/mental harm, health, services

For the adequacy of health sector technical documents (Norms and Procedures For the Prevention and Attention of Family Violence and Child Maltreatment, the Practice Guidelines on Sexual and Reproductive Care, and National Guidelines for the Attention of Persons Affected by Gender Based Violence)

Three measures

- Conformity with Belem do Para elements, contained in art 8 and 9
  Categories:

  Promotion of awareness and observance of the right of women to be free from violence, and the right of women to have their human rights respected and protected

  Provision of appropriate specialized services for women who have been subjected to violence, through public and private sector agencies, including shelters, counseling services for all family members where appropriate, and care and custody of the affected children

  Provision of access to effective readjustment and training programs for women affected to enable them to participate fully in public, private and social life

  Special account of the vulnerability of women to violence by reason of, among others, their race or ethnic background or their status as migrants, refugees or displaced persons, women subjected to violence while pregnant or who are disabled, of minor age, elderly, socioeconomically disadvantaged, affected by armed conflict or deprived of their freedom.
- Conformity with CEDAW elements, including General recommendations 19 and 24
  Categories

  Modification of cultural patterns to eliminate discrimination, subordination, stereotyped roles

Services for women affected, including family planning

Services for victims of family violence, rape, sexual assault and other forms of gender-based violence, including refuges, specially trained health workers, rehabilitation and counselling;

Access to rural women and that, where necessary, special services are provided to isolated communities

Services to ensure the safety and security of victims of family violence, including refuges, counselling and rehabilitation programs, rehabilitation programs for perpetrators of domestic violence; support services for families where incest or sexual abuse has occurred;

Protective measures, including refuges, counselling, rehabilitation and support services for women who are the victims of violence or who are at risk of violence

Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice

- Appropriateness according to the recommendations in *Improvement…*(Bott et al, 2010)

Values and explicit commitments

Reference networks and directories

Privacy and confidentiality

Understanding of legal issues

Continuing awareness-raising and education

Emergency contraception

Educational materials

Medical records and information systems

Monitoring and evaluation

Opportunities to share experiences

OUTCOMES

SPECIFIC OBJECTIVE 1

Recommendations to member states regarding the inclusion of a mental health component in the services for women affected by IPV

Table One shows some general components of CEDAW and Belem do Para Conventions. CEDAW anteceded Belem Do Para by more than a decade. Both documents have "women" as their target population. The focus of CEDAW is on discrimination because it violates the principles of equality and dignity, is an obstacle for the development of women and impedes the establishment of world peace and the development of countries and individuals. Belem Do Para is more concerned with violence, as it is a violation of women's fundamental rights -including the right to life and integrity.

TABLE ONE

GENERAL CHARACTERISTICS OF INTERNATIONAL CONVENTIONS
ABOUT VIOLENCE
AND DISCRIMINATION AGAINST WOMEN

	CEDAW	CONVENTION BELEN DO PARA
Year approved	1979	1994
Year ratified	1981	1996
Monitoring body	Committee on the elimination of discrimination against women, transferred as of Jan 2008 to the Office of the High Commissioner of Human Rights	Inter-American Commission on Human Rights and Inter American Court of Human Rights oversee, also there is the Mechanism to Follow up on the Implementation of the Convention of Belém do Pará (MESECVI) 2004
Binding yes/no	Yes	Yes
Scope: population included	Women	art 5: Every woman

Table Two shows that CEDAW deals with the right to access health services without discrimination in Art 12. There is no specific mention of mental or psychological health in the Convention. However, General Recommendation 24 (The Right to Health) further defines this right, to include attention for psychosocial factors (including depression in general) and socio -economic factors: unequal power relationships, with the risk of violence exposing women and girls to physical and psychological harm. (para 12).

General Recommendation 24 (GR24) mentions other rights protected by other articles in the convention whose protection is indispensable for the full realization of the right to health:

> article 5 (b), which deals with education regarding the social role of maternity
>
> article 10, which requires States parties to ensure equal access to education and to reduce female students' drop-out rates, which are often due to premature pregnancy;
>
> article 10(h) information and advice on family planning;
>
> article 11, the protection of women's health and safety in working conditions,
>
> article 14 (2) (b) access for rural women to adequate health care facilities, including information, counselling and services in family planning, and (h), that deals with the social determinants of health, such as sanitation;
>
> article 16 (1) (e), which requires States parties to ensure that women have the same rights as men to decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to exercise these rights.

General Recommendation 19 (GR19) describes the impact of violence on the ability of women to exercise and enjoy their rights and says that violence constitutes a form of discrimination. Paragraph 24 describes the services for the victims, to protect their

safety and to rehabilitate the perpetrator. Special mention is made of accessibility of services for rural women and of services for families affected by incest.

TABLE TWO

SPECIFIC MENTION OF HEALTH AND MENATLA HEALTH IN INTERNATIONAL NORMS ABOUT VIOLENCE AND DISCRIMINATION AGAINST WOMEN

ANALYSIS MEASURE	CEDAW	BELEM DO PARA
Explicit recognition of right to health	art 10 education and information for health, art 11 protecion of health at work, art 12 elimination of discrimination in the field of health care	art 4 The right to have her physical, mental and moral integrity respected;
Explicit recognition of right to mental health	included in General Rec 24	art 4 The right to have her physical, mental and moral integrity respected;
Recognition of consequences on mental health	in Gen rec 19	art 1 violence…that causes psychological harm
Role of health sector		art 8 e) to provide appropriate specialized services for women who have been subjected to violence, through public and private sector agencies, including shelters, counseling services for all family members where appropriate, and care and custody of the affected children:
General services	In GR 24	art 8 gradual provision of programs
Mental health services	in GR 19	art 8 f) to provide women who are subjected to violence access to effective readjustment and training programs to enable them to fully participate in public, private and social life;

Hence, health and mental health are addressed in these documents. Art I in the Belem do Para convention, explicitly says that violence causes psychological harm. Art. 4 states that every woman has the right to the protection of physical, mental and moral integrity. However, this convention places no priority on mental health and makes no specific recommendations.

Belem Do Para calls for the States Parties to " provide appropriate specialized services for women who have been subjected to violence, through public and private sector agencies, including shelters, counseling services for all family members where appropriate, and care and custody of the affected children" (art 8)

Clearly, both conventions place mental health under their protection because they call for States Parties to protect, fulfill and guarantee the right to health, which includes physical and mental health.

SPECIFIC OBJECTIVE 2:

Evidence of recognition of the right to health including a mental health component in the laws regarding health and violence in Peru

General Health Law:

This law does not make reference to the right of persons to live free of discrimination or the need to change cultural patterns to ensure equality or the elimination of prejudices. Article 6 and 7 protect access to sexual and reproductive services. Article 11 says that all persons have the right to mental health care and defines violence as a mental health issue. It sets forth a model of services in the community with democratic participation, an emphasis on ambulatory services to cover promotion, prevention, attention and rehabilitation. It does not mention integration with primary care or other services. Art 13 says that the right protected in article 11(mental health care) is actionable, either by the interested party or by the state.

Art 15 recognizes the rights of "patients" protected by CEDAW (autonomy, privacy, confidentiality, informed consent and choice). The beneficiaries of these rights are not citizens or users, but "patients".

Special measures, as suggested by CEDAW in GR 19, are only touched upon tangentially. The law mentions Rehabilitation in general in Art 19, this article also prioritizes care for persons with disabilities, which under the terms of the Convention on the Rights of People with Disabilities (CRPD) includes mental disability. There is no specific mention of services, such as refuges, attention to perpetrators, or services for families affected by incest. This law does not address the special needs of rural or minority women.

Law 26260, Unified ordered text of the law for protection against family violence

Contrary to international recommendations, this law does not include violence against women in its name, but rather "Family violence" a fact that places the focus away from the woman and on the family and family relationships.

There is no specific mention of the right to live free of discrimination. Art 3 deals with education in values and attitudes to foster a society with "unrestricted respect for the value and dignity of all persons, and for the right of women, children, adolescents and the family"

The special needs of rural women are mentioned in Art. 3, h)

Special protective measures are mandated within 24 hours in art 10. These are dealt with in detail.

If the perpetrator is sentenced to psychological treatment, a physician must certify completion of the treatment (Art 21).

Confidentiality is protected in art 27.

Certification must include physical and psychological effects of the violence for the purpose of redress. (art 28)

National Plan against violence against women 2009-2015

This document is based on the international and national norms that address the protection, fulfillment and guarantee of the fundamental rights for all persons, including the right to live free from violence and discrimination. It has four approaches: gender, human rights, inter-culturality and integrality. Its principles are public policy based on evidence and results, the development of annual plans to gradually approach its objectives, inter-sectorial and inter-governmental coordination and democratic participation.

Starting at the Introduction, the National Plan incorporates non-discrimination and the enjoyment of rights by women as the foundation of its three-pronged approach: 1. The implementation of actions to guarantee the right to live without violence 2. Access to quality public services 3. Changes in socio cultural paradigms towards relations based on respect of women's rights.

The vision describes (p. 23) a society that guarantees women, without any distinction, the right to live free from violence, in dignity, with egalitarian relationships between men and women and the elimination of discriminatory socio cultural paradigms, in a context of safety and unrestricted respect of human rights.

The plan's three strategic objectives are:

1. To adopt public policies against violence, with a multi-sectorial perspective,
2. To guarantee the access of women to services of good quality: legal and health, and
3. To identify and change socio cultural patterns that maintain inequity and violence.

Services for women affected by violence, including protective and supportive measures correspond to the second strategic objective.

Objective 2.1 calls for the establishment of services for women affected by violence, including: delivery of medication and other resources in cases of sexual violence, the inclusion of mental health services for survivors of violence, the development and implementation of protocols for GBV, and the development of a model for refuges/shelters. This includes implementation and supervision of refuges. Another goal is the development of guidelines to assess psychological sequelae in cases of sexual violence.

Objective 3 deals with the modification of sociocultural patterns. This objective aims for the intervention of the educational sector; in order to identify socio cultural patterns, formulate promotional and preventive strategies to deal with violence and promote change in cultural patterns that render legitimacy to violence, including the inclusion of analysis of gender-based violence in all higher education curricula.

Although there is recognition of the special issues of minority and rural women, there are no objectives or activities targeting these groups.

The plan includes mental health specifically, when it speaks of the need to address the psychological damage that results from violence. It calls for the development of a protocol for the assessment of psychological damage due to violence, inclusion of special services for women survivors of sexual violence during the armed internal conflict and development of a special plan for the care of mental health of women survivors of sexual violence during the armed internal conflict.

Evidence of specific recommendations for the integration of mental health in services for women affected by violence in the practice guidelines issued by the Minister of Health

TABLE THREE

CONFORMITY OF PERUVIAN GUIDELINES FOR THE ATTENTION OF VIOLENCE WITH CEDAW PARAMETERS

ANALYSIS MEASURE	NORMS AND PROCEDURES FORO THE MANAGEMENT AND PREVENTION OF FAMILY VIOLENCE AND CHILD MALTRATMENT	NATIONAL PRACTICE GUIDELINES FOR THE ATTENTION OF SEXUAL AND REPRODUCTIVE HEALTH 2004	NATIONAL GUIDELINES FOR THE ATTENTION OF PERSONS AFFECTED BY GENDER-BASED VIOLENCE
DISCRIMINATION Art 1 (e)			
To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;	Does not mention "violence against women", but includes "all persons"; refers to violence in the family and child maltreatment. Explicitly forbids discrimination on any grounds (p 55)	Specifically mentioned in Module I, which deals with integral care of sexual and reproductive care. In the introduction, sexual and reproductive rights are discussed, with specific mention of the international conventions and other documents, such as conferences and declarations which enshrine the right to health and non –discrimination, as well as other rights that are considered components of sexual and reproductive rights: the right to life, the right to integrity of the person, the right to equality and non-discrimination, free information, education and privacy.	6.2 components of integral attention: Integral attention consists of: the promotion of a culture of good manners, detection of GBV situations, attention to persons affected by GBV situations and referral and follow up of cases of GBV
Art 5 a To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based	No explicit mention, says authorities are to coordinate with the task force on gender and prevention and attention of familial violence	In the introduction, there is a discussion of gender and gender roles. There is also specific mention that a gender perspective in sexual and reproductive health implies the identification and modification of the causes that give rise to asymmetrical power relationships with subordination of women who find themselves at disadvantage when it comes to the access and control of resources	V general considerations: promotion of a culture of good manners Recognition that a person has intrinsic value

on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;		of health care for their benefit. Health problems and services are gendered, therefore, a gender perspective should contribute to lower mortality and morbidity resulting from (gender) inequity and should improve the quality of life of women and men in the families.	
10 (f) The reduction of female student drop-out rates and the organization of programs for girls and women who have left school prematurely;	Not mentioned	NOT MENTIONED	
12 1 States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.	These guidelines do not specify "violence against women" which is included in family violence. There is no mention of family planning, although unwanted pregnancy and abortion are considered suggestive of violent situations at home.	Specifically mentioned in the Introduction, also mentioned in Module VII, which describes family planning and starts with a discussion of the rights of the user of family planning services	
Gen rec 19 11th session			
Gen rec 19 11th session 1992- para 24 k) States parties should establish or support services for victims of family violence, rape, sexual assault and other forms of gender-	Provisions for training of health workers for the recognition of symptoms and other indicators of violence, use of the "screening instrument",	Specifically mentioned in the Introduction, also mentioned in Module VII, which describes family planning and starts with a discussion of the rights of the user of family planning services	V. General considerations: health establishments at all levels in charge of specific promotion, prevention, attention and rehabilitation in GBV. ER attentions the certification of lesions shouldn't have any cost.

based violence, including refuges, specially trained health workers, rehabilitation and counselling;	Calls for setting up services in all health establishments, that would endeavor to: Stop the violence Rehabilitate the person from untoward physical, psychological and social effects of violence Strengthen and develop personal and social skills to take decisions, solve problems and overcome conflict without resorting to violence Prevent new situations of violence The interventions carried out would be physical, psychological (counseling, therapy) with referral to specialists.		VI. 6.1 Components of integral care: promotion, recuperation, rehabilitation Promotion centered in a culture of good manners and strengthening the family healthy behaviors. Training of all personnel on recognition of signs and symptoms of GVB and in the services available for people affected by GBV, schedules and instruments. Recuperation: detection of cases via active search in all clinics, use of questions and form, attention of affected persons, referral, counseling when needed, special environment for teenage users, Rehabilitation is the responsibility of specialists, who will receive the referred cases and counter refer them once the process is done
(o) States parties should ensure that services for victims of violence are accessible to rural women and that where necessary special services are provided to isolated communities	No specific mention	As this document, including the protocol on violence, is mandatory in all establishments that provide sexual and reproductive health services, it has the widest scope: SRH workers are supposed to implement the guidelines contained in the protocol in every corner, including rural areas	No specific mention, except that GBV is taken care of in all establishments at all levels. There is no provision for transportation in case of referral to a hospital. Home visits only for users who fail to show up at appointments.

Para 24 r) (iii)Services to ensure the safety and security of victims of family violence, including refuges, counselling and rehabilitation programmes; (iv) Rehabilitation programmes for perpetrators of domestic violence; (v) Support services for families where incest or sexual abuse has occurred;	iv) Perpetrators of violence are considered "cases" of violence. As the family is the focus of intervention, persons who suffer from violence as well as those who perpetrate violence should receive attention. However, there is no description of intervention for perpetrators of violence against women. There are some psycho-education points to be discussed with parents who mistreat children v) this point is not mentioned	iii) Describes an emergency plan, suggests referral to a refuge, a psychologist or legal services	
Para 24 t) (iii) Protective measures, including refuges, counselling, rehabilitation and support services for women who are the victims of violence or who are at risk of violence	Mentions referral to refuges in the community. It also specifies how to proceed if the woman feels her safety is at risk (p 70)	The guidelines suggest referral if there is danger for the security of the woman	Coordination with other sectors of the state, civil service or women's organizations and private entities for support services, rehabilitation, in order to secure "diagnostic precision,
Rec 24 20th session 1999			
Para 31 e (e) Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;	There are no provisions for autonomy of the person, although informed consent is mentioned. There is mention of the need to insure confidentiality and privacy. Women are not considered as individuals, and the problem of violence against women is	This document stars with a description of human rights and their features: (Introduction, page 2): innate or inherent to the person, universal, inalienable, accumulative, irreversible, invulnerable, obligatory, indivisible, independent, complementary and non-hierarchical, and transcend national frontiers Autonomy of the person is fostered in the text, with suggestions to ask the woman for	V. General considerations: the affected person should decide whom she/he feels most comfortable with. If the person is unable to respond to questions, the health provider *should address the accompanying person or else collect only basic information.* V!. 6.1 Basic requirements: human resources: All health care providers should be trained to do counseling in all establishments

	not explicitly mentioned. The needs and choices of women are subsumed un the family, for instance, the definition of family includes all those who live under the same roof and share bonds of affection or blood *and* those who the head of the family considers close. (p 96	her opinion and not pressure her to leave the aggressor or similar, to be examined by a person of the same sex if so desired, to give her consent and to be interviewed and examined in a private environment	Each primary level establishment will have one trained person in charge of crisis intervention, detection and referral In hospital, professional personnel in charge of counseling, detection, referral, treatment and rehabilitation All personnel should be acquainted with screening questions, and these should be used included as routine in all contacts Attention could happen in the establishment, in a setting which offers privacy, confidentiality and safety; and outside, for promotion and prevention activities

TABLE FOUR

CONFORMITY OF PERUVIAN GUIDELINES ABOUT VIOLENCE AND ELEMENTS IN THE INTER-AMERICAN CONVENTION ON THE PREVENTION, PUNISHMENT AND ERADICATION OF VIOLENCE AGAINST WOMEN "CONVENTION OF BELEM DO PARA"

Analysis measure	Norms and Procedures For the Prevention and Attention of Family Violence and Child Maltreatment	Practice Guidelines on Sexual and Reproductive Care, Module 1	National Guidelines for the Attention of Persons Affected by Gender Based Violence
Art 8 obligations of States parties			
A, a. to promote awareness and observance of the right of women to be free from violence, and the right of women to have their human rights respected and protected;	In General Principle (3.4) the document states that all people have the right to live in conditions that assure their development and respect for their rights (3.6) and persons affected by violence have the right to services without discrimination	Explicit purpose of the guidelines: to provide integral care for sexual and reproductive health, which implies the right to make informed decisions and have these decisions respected without discrimination	Explicit purpose to aid in the care of persons affected by violence, no explicit mention of the rights of women; the activities prescribed are: Promotion of a culture of good manners, case finding, attention to persons affected and referral and follow up (1)
d. to provide appropriate specialized services for women who have been subjected to violence, through public and private sector agencies, including shelters, counseling services for all family members where appropriate, and care and custody of the affected children;	The Ministry of Health assumes the responsibility to provide health services and promote the institutionalization and sustainability of activities for prevention and attention as well as information systems to deal with the problem of family violence and child maltreatment	Has provisions for the screening, attention and referral of women who have suffered from physical, psychological and sexual violence; describes safety measures and referral to refuges. Provides for ETS prophylaxis and EC in case of sexual violence	Has provisions for services in all establishments, these are for persons affected by violence, doesn't explicitly mention violence against women in the activities, although the background and conceptual discussion refers mostly to women, includes services for perpetrators and other members of the household,
f. to provide women who are subjected to violence access to effective readjustment and training programs to enable them to fully participate in public, private and social life;	This document makes no mention of rehabilitation	Only mentions referral	Rehabilitation is mentioned as belonging to the specialized level. P 12
Special account of the vulnerability of women to violence by reason of, among others, their race or ethnic background or their status as migrants,	Special considerations for children and adolescents, pregnant women, older adults.	Special considerations for children and adolescents and pregnant women throughout the entire document, does not mention other special populations	Special consideration is given to children and adolescents, pregnant women in promotion; older women, indigenous, migrant, or

refugees or displaced persons, women subjected to violence while pregnant or who are disabled, of minor age, elderly, socioeconomically disadvantaged, affected by armed conflict or deprived of their freedom.			other groups not mentioned

Norms and Procedures for the Prevention and Attention of Family Violence and Child Maltreatment (2001)

This technical guidance document has the stated purpose of providing orientation for the management of family violence and childhood maltreatment in order to allow prevention and to assist in the recovery of the affected persons' health. The objectives are

1. To establish the criteria for the promotion, prevention and attention of violence in the family and child maltreatment,
2. To allow for training, supervision and evaluation of health personnel and
3. To define responsibilities in the MoH network of establishments.

It consists of General Principles, legal basis, general and specific norms (promotion, prevention, detection, attention, training, reference, statistical information system, and epidemiologic vigilance), procedure, flow diagrams, the role of health providers, responsibilities of the different professions, and responsibilities of Modules for the Attention of child maltreatment.

Health establishments of the 1st and 2nd levels are supposed to provide emotional support; those in the 2nd level are asked to provide crisis intervention, and 3rd level establishments –especially those that deal with maternal, pediatric, adolescent and mental health- are asked to provide specialized treatment. The flow diagram includes mental health assessment after disclosure of violence. However, there are no guidelines for this procedure, even though it is supposed to happen in the 1st and 2nd level centers, where there are no specialists.

The description of the activities at all levels includes “integral assessment” of health and emotional support and treatment. However, the integral assessment of the person affected does not include a mental status exam.

Treatment should be available for the affected, the aggressor and other people who may feel affected by the violence.

The person in charge of mental health has the responsibility to start and lead the external reference/counter-reference network to support violence victims.

These guidelines have an annex that describes counselling procedures. There is also a form for universal screening for violence, developed specially for this technical document in 2001, probably following the tendencies of the late 90?s.

In terms of conforming to the parameters of CEDAW and Belem Do Para, the General Principles state that persons have the right to live without violence (3.4) and that they should access services without discrimination. In this document, the Ministry of Health assumes the responsibility to provide health services and promote the institutionalization and sustainability of activities for prevention and attention as well as information systems to deal with the problem of family violence and child maltreatment.

However, this document refers to “Family violence”, a term that makes violence against women invisible and that may result in a woman being penalized for exposing to children to violence in the house, even if she is a victim as well. Because violence against women is not the focus, promotional and preventive activities are geared towards the creation of a peaceful environment, without any recognition of the cultural patterns that, through gender inequity and male dominance result in violence against women. For instance, there is a strong emphasis on providing motivation and education in social skills, to allow people to negotiate their conflicts without resorting to violence, without any attention paid to gendered power asymmetries. The stability of the family takes precedence over the wellbeing and protection of the affected woman.

There are provisions for children, adolescents and older persons; there is no mention of rehabilitation or of the needs of rural women.

National guidelines for the integral care of sexual and reproductive health. Module 1, Integral care: Protocol on violence (2004)

The document consists of eight modules. Module 1 deals with human rights, the gender perspective, how to approach the person who presents for sexual and reproductive health issues, and how to deal with persons affected by violence.

The explicit purpose of the guidelines is to provide integral care for sexual and reproductive health, which implies the right to make informed decisions and have these decisions respected without discrimination.

The different types of violence are described. The guidelines summarize Peruvian law to emphasize that it protects women from gender-based violence.

General criteria for treatment include an empathic, non-judgmental attitude, respect for the woman's autonomy and choice, confidentiality and privacy, the need to take note of what the woman says and of the findings of the physical examination.

The mental status examination is not mentioned.

The document has provisions for the screening, attention and referral of women who have suffered from physical, psychological and sexual violence, describes safety measures and referral to refuges. It provides for prophylaxis for sexually transmitted diseases and emergency contraception in case of sexual violence.

There are provisions for referral if the woman has emotional sequelae; however, the mental health status exam is not a procedure for determining the existence of mental health issues

In terms of conforming to CEDAW and Belem do Para parameters, (Table Four) the guidelines mention non-discrimination in in the introduction to Module 1 along with the discussion on rights, with specific mention of the right to life, the right to integrity of the person, the right to equality and non-discrimination, free information, education and privacy. There is a discussion of gender and gender roles. There is also specific mention that a gender perspective in sexual and reproductive health implies the identification and modification of the causes that give rise to asymmetrical power relationships with subordination of women who find themselves at disadvantage when it comes to the access and control of resources of health care for their benefit. Health problems and services are gendered; therefore, a gender perspective should contribute to lower mortality and

morbidity resulting from (gender) inequity and should improve the quality of life of women and men in the families.

In compliance with paragraph 24 k) of GR 19, Module I includes a protocol for the attention of violence against women. There are also guidelines for the attention of women suffering from sexual violence, including specimen collection for the identification of the aggressor and prophylaxis for STD as well as emergency contraception. The protective measures mentioned in para 24 t) would fall outside the scope of health services, but users of the guidelines are asked to adequately refer the woman to other services.

Autonomy of the person is fostered in the text, with suggestions to ask the woman for her opinion and not pressure her to leave the aggressor or similar, to be examined by a person of the same sex if so desired, to give her consent and to be interviewed and examined in a private environment. In compliance with GR24, para e) the guidelines offer a description of the rights that have to be protected in health services for women.

Rural women are included in the wide scope of the guidelines as determined by Belem Do Para in art 9. This document is mandatory in all health establishments, at all levels wherever there is a sexual and reproductive health (SRH) worker. Every health establishment countrywide is staffed with a SRH provider, either a physician or a midwife. In this sense, it protects and guarantees the access of rural women to basic services if she suffers IPV.

This document does not mention rehabilitation services, either for the woman or for the perpetrator. It does not mention special counseling for families affected by incest.

National Guidelines for the Attention of Persons Affected by Gender-based Violence (2007)

The purpose of the guidelines is to contribute to the improvement of health services for persons affected by violence.

The general objective is to establish the basic procedures to give health care to persons in the issue of gender-based violence. It has three specific objectives:

1. To integrate conceptual frameworks for the development of activities of health care for persons affected by GBV

2. To present a series of procedures for the integral promotion, prevention, attention and rehabilitation of physical and mental health of persons affected by GBV
3. Strengthen the capacity of health workers to respond to GBV.

Integral attention consists of: the promotion of a culture of good manners, detection of GBV situations, and attention to persons affected by GBV situations with referral and follow up of cases of mental health involvement.

The guidelines list the obligations derived from the law:

- All health establishments must participate in the attention of GBV, with activities in the three levels of prevention,
- Emergency services and certification are free,
- The user's choice of provider is to be respected,
- The victim, the perpetrator and the other members of the household are considered to be affected by GBV,
- There should be services for all, referral to other sectors for legal and protective measures, training of personnel and respect for the rights of the person.

The integration of the conceptual framework is centered in understanding GBV as a public health problem that violates human rights. Cedaw's GR 19 is used as the basis to define violence and understand it as a form of discrimination against women. There is no discussion of the health impact of GBV.

The guidelines recognize that "Family" violence occurs in the context of GBV, but GBV also includes other forms of violence, such as sexual harassment. The focus of the guidelines is thus, not clearly on the care of women affected by IPV.

Power asymmetry is at the root of GBV, as in the PAHO references used in this document. Notwithstanding this statement, the etiology of violence is explained only in terms of the ecological model developed by WHO and there is no further mention of gendered issues of empowerment, control, or submission of the woman.

Specific considerations include trained human resources and infrastructure that protects confidentiality and privacy. The necessary materials are a copy of the GVB guidelines, a copy of the guidelines for sexual and reproductive health care, educative materials and a directory of local institutions for referral.

The components of integral care are promotion, recuperation, rehabilitation. These are described in Part VII.

Promotion consists of fostering a culture of good manners and strengthening the family healthy behaviors. The description of the promotional and preventive activities is lengthy and covers both the community and the health centers.

Recuperation refers to detection of cases via active search in all clinics, use of questions and ad-hoc form, attention of affected persons, referral, counseling when needed, differentiated services for teenage users.

Attention to the cases is the responsibility of mental health and SRH providers. The evaluation includes the following steps: physical exam, history of present illness, evaluation of risk, diagnosis.

There is no mention of mental status exam or active search for depressive, anxious or post -traumatic stress symptoms or signs.

Rehabilitation is the responsibility of specialists in mental health, who will receive the referred cases and counter refer them once the process has finished.

The legal framework, screening instruments, questions for detection, care for survivors of sexual violence and flow diagrams appear as Annexes, not as a part of the guidelines proper.

The Peruvian guidelines and the recommendations set forth in "Improving the Health Sector Response to Gender Based Violence"

TABLE FIVE

APPROPRIATENESS OF PERUVIAN GUIDELINES, ACCORDING TO PARAMETERS SET FORTH IN *Improving the Health Sector Response to Gender Based Violence, A Resource Manual for Health Professionals in Developing Countries,* Section III Improving the Health Service Response

Content measure	Norms and Procedures For the Prevention and Attention of Family Violence and Child Maltreatment	Practice Guidelines on Sexual and Reproductive Care Module I	National Guidelines for the Attention of Persons Affected by Gender Based Violence
Values and explicit commitments	General Principles: recognize violence as abnormal and illegal, with serious consequences on health, recognize the right of persons to live in a violence free environment, and the right of persons to receive care of affected by violence, from a multidisciplinary tea, using the ecological model and protected by the law. No explicit mention of women or violence against women	Introduction explicitly recognizes the states' obligation to protect, fulfill and guarantee the right to health without discrimination. Sexual and reproductive health (the focus of the document) includes the complete state of physical, emotional and social wellbeing and violence against women hinders a woman's enjoyment of her rights and has serious health consequences on her health..	General considerations: There is no specific mention of the right to health, or the right to live in a violence and discrimination –free environment. Guideline prescribes that all establishments at all levels should carry out the activities described in the guidelines, but does not state the explicit commitment to deal with violence against women. The second section, Basic concepts describes violence against women as a human rights problem. The damage to mental health is not mentioned. The stated criteria for all attentions are warmth, quality, honesty, opportunity
Reference networks directories	Mandates reference to public and private institutions, describes the process of building a network in communities (p 36) it does not mandate a directory of institutions	Mandates reference to private or public institutions for psychological, legal and other services, including shelters It does not mandate a directory of institutions for referral	Describes criteria for reference: opportunity, capacity to solve, accessibility; mandates reference in all instances, except tertiary level establishment (specialist), Mandates directory of local institutions
Privacy and confidentiality	Protects privacy and confidentiality	Protects privacy	Infrastructure of the establishment: should protect the privacy of the person
Understanding of legal issues	Refers to the Law against Family Violence 26260	It refers to the Lay 26260, the National plan against	In an annex, it refers to international and national

		violence and international law	law against violence, detailing the multiple changes in the "Unified text" that has gradually incorporated international recommendations. It also mentions the national plans against violence, and other pertinent plans: mental health, child and adolescents health, human rights, equal opportunity but does not describe them
Continuing sensibilization and education	It is the responsibility of professionals in the MoH to promote training of all personnel in this area	Not explicit	Explicitly mentions that all personnel of all establishment has to be sensibilized and educated about violence
Emergency contraception	No	Prescribed for sexual violence	Information about emergency contraception should be given to women who were not using contraception when raped.
Educational materials	Suggested	Suggested	Suggested
Medical records and information systems	Registration of cases in clinical history, statistical reporting, no special violence register Mandates participation in epidemiological vigilance	Registration of all findings in clinical history, statistical reporting, no specific register of cases	findings of screening in the Screening form, attention of affected cases in the clinical chart, statistical reporting, no special register
Monitoring and evaluation	Under the responsibility of the Regional Health Director	Not mentioned	Not mentioned
Opportunities to share experiences	Not specifically mentioned	Not mentioned	Not mentioned

Survivors of GBV have a great need for privacy, confidentiality, security, respect, and emotional support[88]. Bott et al [89] have identified key elements to help establishments to train providers and be ready to respond to these heightened needs. Table 5 shows whether these minimal requirements are met by the guidelines under review.

The commitment to improve women's health and reduce her exposure to violence is not explicit in either the 2002 or the 2007 documents. The Norms and Procedures (2002) refers to "family violence", not violence against women, with a focus on restoring the balance and wellbeing of the family, not on the protection of the woman. The guidelines on GBV (2007) refer to the "person" affected, in spite of having defined "Gender based violence", according to UN- DEVAW, as that perpetrated against a woman because she is a woman.

Only the 2007 guidelines include the need for a directory, although all recommend reference to specialists, legal services and services in the community for refuge and support.

The three documents protect privacy and confidentiality.

Normative frameworks, including international conventions and national legislation, are invoked in the three documents. However, even if CEDAW and Belem Do Para obligations drive the involvement of the health sector, only the SRH guidelines include a discussion of the gender perspective of violence against women: asymmetry of power, unequal distribution of resources and the submissive role of women. The apparent neutrality of the other two documents detracts from their clarity.

The guidelines for GBV (2007) list the obligations of health providers that stem from the Law against Violence: free certification, protection of confidentiality, attention at all levels, obligation to inform authorities if a minor is affected.

The guidelines on SRH are a training instrument. The other two mandate training and continuing education, although specific training on mental health is not explicitly mentioned.

Educational materials are suggested, but none of the guidelines describes the contents of these materials.

Emergency contraception is not mentioned in Norms and procedures 2001, it is prescribed in the SRH guidelines and the National Guidelines says that the woman should only "receive information about it".

Monitoring and evaluation is the responsibility of the Regional Director of Health only in the Norms for Family Violence and Child Maltreatment. The other documents do not define this responsibility.

None of these documents makes a provision for a space in which health care providers may share experiences and discuss difficulties.

DISCUSSION

The results of this analysis show that although the international conventions signed by Peru on the matter of protecting women from violence, fully protect the right to health, including mental health, the MoH technical norms incorporate the mental health component inadequately and incompletely.

Both CEDAW and Belen do Para, drafted and approved at a time when public health focus was on the reduction of mortality alone, include psychological and emotional health under their protection. Particularly GR24 explicitly mentions in paragraph 25 the risks to mental health due to social hardship and unequal conditions in women's lives; in paragraph 28 it warns about the emotional harm that results from child marriage. GR24 calls States parties to take action and report on how they are dealing with the "different forms of violence which can affect their health" and with the psychological damage caused by sexual violence in girls and adolescents.

There is however, a problem in the translation of these principles into legislation and later, into technical norms for the use of the health sector.

The Law for the Protection against Family Violence starts out making violence against women invisible. International recommendations state that laws against violence must clearly state their purpose[90] to avoid losing the gender perspective and secondary victimization of women. Laws that deal primarily with "family violence" in order to achieve gender neutrality may be subject to manipulation by violent offenders and tends to give more importance to the stability of the family than to the safety and wellbeing of the woman survivor of violence.[91] It does not make any provisions about discrimination or recognize in any way that violence against women results from power imbalances. However, it mandates changes in the educational system to insure a change in attitude and it recognizes that there will be physical and mental consequences of violence. In article three, the law establishes, among others, that the affected person should receive medical assessment and services. The law recognizes psychological damage for redress purposes.

Peruvian General Health Law (GHL) has been criticized because it does recognize health as a fundamental right. The state only recognizes the obligation to provide public health measures, it does not provide primary care for all the population – only emergency services are guaranteed. [92] The GHL does not recognize the rights of citizens who use

health services (only limited “rights of the patient”, in article 15)[93]; thus, the only way in which a person may address the health establishment is as a “patient”,not as a “citizen”. This is a paternalistic view that permeates the organization of services and the behavior of providers.

Article 11 of the GHL includes violence among mental health issues, along with psychiatric disorders and drug related disorders. This has one advantage: Article 13 says that lack of access to mental health care is actionable. However, this reductionist view of violence, including gender-based violence reinforces the failure of health providers to recognize the impact of violence on a woman’s health and rights and to continue to consider it not relevant to their everyday practice.[94] It also runs counter to recommendations that the approach to violence be multi-systemic and comprehensive. [95]

The National Plan for Violence against Women 2009-2025, being a more modern instrument, is explicit in the inclusion of mental health activities to achieve its Strategic Objective 2 (2.2: to guarantee access and quality of services at the national, regional and local levels). The expected products from the MoH are the implementation of mental health services for women affected by violence, the implementation of mental health services for women living with HIV affected by violence. The planning, validation and implementation of shelters and the implementation of a supervision system for shelters for women affected by violence, the training of psychologists to assess the psychological damage of women subject to sexual violence and the production and implementation of clinical guidelines for the attention of gender based violence (but this does not say “mental health” only).

Thus, the state has set some tasks for the health sector that pose several challenges such as the level of involvement of the health sector, the questions regarding autonomy of the patient, the strategies for the recognition of the affected persons and the training, supervision and evaluation of the providers. Several authors and organizations such as WHO, PAHO, IPPF have produced recommendations and guidelines to improve the health sector response and summaries of successful experiences that would be useful as paradigms.

These recommendations have stressed the multi-sectorial nature of the response to violence against women, where primary promotion calls for the participation of sectors besides health, in activities such as the control of alcohol consumption, the empowerment

of women or the creation of a climate of non-tolerance of intimate partner violence.[96] Health care providers are crucial for secondary and tertiary promotion (early recognition and rehabilitation).

Early recognition of the affected, according to the latest WHO Guidelines[97] should be guided by the principle of "first do no harm", that is, before asking a woman about violence, certain conditions should be met to insure her safety and the appropriateness of the response. These are 1. A standard operating procedure, 2.Training on how to ask and how to respond, initial response and beyond, 3. A private setting, confidentiality insured and 4. A referral system. These requirements make universal screening very difficult to implement. This is in line with the questioning of the ethical adequacy of screening[98],[99]and with the lack of evidence regarding improvement in the outcomes for women.[100]

Literature stresses a sympathetic, non-judgmental manner that signals to the woman that she is not alone, that there is a space where she can talk.[101] As important as this, is the care for the woman's safety, privacy and confidentiality. These are not always easy to protect, for instance in a small community, where everybody knows everybody else.

WHO guidelines[102] describe the first line response so:

- ensuring consultation is conducted in private ensuring confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting or when a child is in danger)
- being non-judgmental and supportive and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved)
- helping her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.[103]

The guidelines are also remarkable because of the definition of what must be done in terms of attention of mental health involvement. If the person has no previous history of mental disorders, there is no indication to prescribe antidepressants or other psychoactive medications during the first contact. Women who have a history of mental health disorders and who are undergoing violent experiences must receive care according to the mhGAP guidelines.

The complete evaluation of lesions and mental health status[104] is another important consideration, because the results will shape the interventions that follow, including referral and procedure in the law and order system.

The integration of mental health care in primary care is the recommended pathway to increase access to mental health services and protect the rights of users[105], particularly in low and middle-income countries[106]. In the Latin American context, the Declaration of Caracas [107] calls for the establishment of mental health services in the community away from psychiatric hospitals, and is the political blueprint for the integration of mental health in primary care. Peruvian health law (GHL) states in Article 11 that mental health should be taken care of in a community center, under multidisciplinary approaches, with participation of the user and the community and preferably as ambulatory services, in the context of the family and the community. It Is not explicit on the issue of integration with other services.

Recommendations for this integration include, according to WHO, a systemic organization, where the entire health system is involved in the organization and implementation of services based on principles of accessibility, coordinated care, continuity, effectiveness, equity and respect for human rights.[108]

Activities indispensable for integration are: [109]

1. training of primary care staff
2. avoidance of overburdening of current staff: hiring more workers
3. adequate supervision with regular availability of specialists to give advice. This cannot be substituted for with referral/counter referral schemes
4. provision of adequate infrastructure that guarantees privacy and availability of medication with clear rules about its use.

The three Peruvian technical documents for the attention of victims of violence (Norms and Procedures for the Prevention and Attention of Family Violence and Child Maltreatment, [Norms 2001]; National guidelines for the integral care of sexual and reproductive health. Module 1, Integral care: Protocol on violence, [SRH2004] and National Guidelines for the Attention of Persons Affected by Gender-based Violence,[GBV 2007]) succeed in the integration of the mental health component incompletely.

The reasons for these shortcomings have to do with the characteristics of the legislative framework from which the guidelines originate. The Law for Protection against Family Violence does not clearly identify discrimination and gender inequities as underlying violence against women, it does not identify women as beneficiary and it does not endeavor to protect the survivor of violence and restore her wellbeing (health) and autonomy. Ortiz Barreda and Vives Cases[110] have examined the adequacy of laws against violence in terms of their inclusion of the key elements recommended by WHO and PAHO, and our law scores well in its multi-sectorial nature.

The GHL does not have a strong human rights underpinning. It does not recognize citizenship of the people it serves, referring to them only as "patients" and has been questioned because of incomplete protection and guarantee of the rights of the persons that approach the health system. Furthermore, it has relegated violence and the health consequences of violence- a public health and human right issue- to a mental health problem.

There are other areas, related to the technical capabilities of MoH that are also deficient, if measured against international standards.

There is apparent gender neutrality, which in fact is gender blindness, which results in lack of clarity in the protection of women. For instance the GBV 2007 defines gender based violence according to CEDAW GR 19 (that which **affects a woman because she is a woman)** and then goes on to refer to "the person affected" (un-gendered) throughout the document. Both Norms 2001 and GBV 2007 lack a discussion of gender inequity and imbalances of power distribution as contributive to violence.

One of the effects of this lack of conceptual clarity is that primary prevention is limited to consist of the creation of a "culture of good manners". According to Jewkes[111] primary prevention should include creating a climate of non -tolerance of IPV, empowering

women and improving their status in society, reducing the use of violence, changing community norms, addressing poverty and alcohol use as risk factors and carrying out pertinent research and monitoring.

There is an overwhelming amount of activities to be carried out by the health worker, some of them outside the establishment carrying out primary prevention activities. This is unwise because health personnel are scarce and current recommendations for integration of mental health care in the primary level warn against it. Furthermore, it has long been recognized that primary prevention is a multi-sectorial effort, led in Peru by the Ministry on Women.

This results in the omission of activities that could be considered central to the attention of a victim of violence. A supervision carried out by the Ombudsman Office of Peru[112] on the services offered to women affected by GBV showed that most women affected by sexual violence in five regions of the country who received attention in mental health settings did not have any laboratory tests or receive prophylaxis for sexually transmitted infections. Most women were referred to specialists outside of the center of the first attention. Only 42 % providers look for and deal with physical lesions. Only 24% discussed a safety plan and only a third promoted the autonomy of the affected woman.

Even though violence has been characterized, in Peruvian health legislation, as a mental health problem, none of the three guidelines recommends that the affected woman have a mental health status exam. This is unfortunate because mental health status exams are very structured and provide good information for diagnosis and disposition, for instance, referral.

Another big omission is the administration of emergency contraception to women subject to rape. GBV2007 say that the woman must be "informed" about the use of EC only. This is very serious in a country where abortion is very restricted and not allowed in case of rape. The mental health damage caused by unwanted pregnancy resulting from rape is great. The lack of contraception measures add to the woman's worries and complicate the peri-traumatic response[113], a factor that has been linked to the development of post - traumatic stress disorder. Unwanted pregnancy from rape may lead to suicide.

On the subject of referral, only the GBV2007 ask for a directory of community services, even though they all mandate prompt referral. Referral is complicated further by the fact that mental health services are unavailable in large portions of the country, where only 9% of all health establishments deliver mental health services.[114]

Training and education of personnel is a difficult point. All three guidelines refer to in-service training for the use of the guidelines and for the actual inquiry about violence, but there is no reference to the participation of mental health providers in the training, supervision and counseling of primary care providers. This activity is necessary when incorporating non-specialists in mental health care.

Guidelines should be updated instruments, in order to fulfill their purpose (to assist practitioners and patient decisions about appropriate health care for specific circumstances[115]). However, in the GVB 2007 we can see that they have the same for the screening for violence that was devised in 2001. This outdated form is difficult to apply, there is no evidence of its usefulness and apparently deters personnel from its use[116].

In summary, the multiple guidelines, which do not share a unitary approach to the problem of violence against women and which do not conform to international standards and recommendations seem to account for the lack of success in the response to GBV of the health sector in Peru.

CONCLUSIONS AND RECOMMENDATIONS

1. The Convention on the Elimination of Discrimination against Women (CEDAW) and the Inter-American Convention on the Prevention Punishment and Eradication of Violence against Women clearly recognize women's right to the enjoyment of the right to health, including mental health. Likewise Peruvian health law protects mental health and the legislation and policy on violence do so as well.
2. In spite of the nominal recognition of the right to mental health in Peruvian General Health Law and Law for the Protection against Family Violence, the lack of a rights and gender perspective of these legal instruments sets the stage for the ambivalent and technically defective practice guidelines that seek to implement, at the everyday clinical practice level, the principles enshrined in Peruvian law
3. Peruvian law defines violence as a mental health problem. This definition does not serve survivors well: it places them in an unfavorable position in legal custody proceedings, raises the possibility that their voice will not be taken seriously and increases their isolation and stigmatization, identifying them as mental cases. Instead of guaranteeing access to quality mental healthcare as needed, this has resulted in a deformed model of attention, in which attention is taken away from physical lesions, and not adequately given to psychological/ emotional/ psychiatric issues either, as not even the mental health status is part of the evaluation.
4. The health sector has three instruments that constitute the technical guidelines for the integral attention of women affected by gender-based violence. These instruments lack unitary concepts and development and have several shortcomings in terms of the key elements of national and international recommendations.
5. The role of the health sector is not well defined in the practice guidelines reviewed. The National Plan for Violence is clear in defining the role of the health sector, expected to provide health assessment and services; the guidelines however include a list of activities ranging from promotion to inter-sectorial coordination of advocacy, in detriment of the essential activities: to ask, inform, assess, document and refer, in the context of a systems approach.
6. The advent of the "Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines" (2013) is timely because this evidence-based document may prompt a revision of the current clinical practice

guidelines on the care for IPV survivors, to produce a single guideline that complies with recent recommendations.

RECOMMENDATIONS

1 Healthcare policy and services:

a. The integration of IPV services in other services, with different points of entry, for instance sexual and reproductive health, pediatrics, emergency and accident departments and mental health (Rec 5, WHO 2013, p 8)
b. Services designed with a clear rights and gender perspective, centered on responding to the needs of the citizens that present for services
c. Attention to the dilemmas and difficulties of the healthcare providers, in view of the high prevalence of IPV, which may also affect providers and their families

2. Training of healthcare providers:

d. Incorporation of training on first line services for IPV and sexual assault survivors given to healthcare providers at pre-qualification level (Rec 4 (30), WHO 2013, p 7)
e. In-service training for healthcare providers that teaches them how to ask, the best way to respond and how to collect forensic evidence; addresses basic knowledge of the legal context, knowledge of existing services, inappropriate attitudes among providers (Rec 4 (31), WHO 2013, p 8)
f. Training for IPV and sexual assault care should be integrated, as they commonly occur together
g. Training must include gender issues and human rights

3. Mandatory reporting of IPV :

    a. The law needs clarification and updating in this regard, in order to complain with the recommendation by WHO that reporting be at the demand of the woman, in which case, she should receive assistance.

4. Woman-centered care: (rec 1, WHO 2013, p 16)
    a. All personnel need to be continuously trained, reminded and reinforced in the right attitudes: nonjudgmental listening, empathy, offering

assistance without interfering, asking for the history without pressing, being careful with privacy and confidentiality.

5. Identification of IPV survivors
    a. Universal screening: no longer recommended, rather a clinician should be prepared to ask when the situation warrants concern about IPV in order to complete identification/diagnoses and insure better subsequent care. (Rec 2, WHO 2013, p 18)
    b. The minimum requirements for asking about violence: a protocol or standard operating procedure; training on how to ask, and the minimum response or beyond; a private setting and confidentiality ensured – the partner is not present-, and a referral system in place
6. Mental health care of IPV and sexual assault survivors (Rec 2.2.1 WHO 2013, pp 20 ff)
    a. First line support addresses mental health needs of women survivors of IPV (Rec 1)
    b. The care of every woman assessed for IPV should include a mental health status exam
    c. There is no evidence to recommend group therapy for survivors
    d. Cognitive behavioral therapy is effective for women suffering from PTSD
    e. Women with pre-existing mental disorders or IPV related mental disorders (alcohol abuse or depression), adequately evaluated, should receive care according to national guidelines (which in turn should follow the recommendations in the Mental Health Gap action Program[117])
    f. Women survivors of sexual assault should not be debriefed.
    g. Women survivors of sexual assault must be offered emergency contraception. It is unacceptable that they are "informed about it" only.
    h. Initial care should include first line support (Rec 10)
        i. Offer help and comfort to help reduce anxiety, provide practical help and support in response to her needs, but not intruding, offering help to connect with social services and other support
    i. The complete history must include the mental health status exam (rec 11)
    j. Up to three months post-trauma

   i. Women who are not incapacitated, and do not suffer from depression, alcohol abuse, psychotic symptoms, suicidality or PTSD should receive "watchful waiting"
   ii. Women suffering from PTSD should receive CBT
   iii. Women suffering from other conditions should receive care according to current guidelines, or the mhGap Action program.

7. General health law: needs to incorporate a rights perspective, with explicit recognition of the right to the highest attainable standard of health for all citizens, and a clear gender perspective to preclude the discrimination that results from "gender-neutrality"
8. It is very necessary that the country develop and pass a Mental Health Law to respond to the severe shortcomings in mental health care in Peru.

REFERENCES

[1] United Nations General Assembly Resolution 48/104, Declaration on the Elimination of Violence against Women, 1993. At http://www.un.org/documents/ga/res/48/a48r104.htm, accessed June1, 2013

[2] CEDAW General Recommendation 19, in General recommendations of the Commission of the Elimination of Discrimination against women. At http://www.un.org/womenwatch/daw/cedaw/cedaw25years/content/english/General_Recommendations_1-25-English.pdf, accessed May 20, 2014

[3] Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2002.

[4] UK Government. Guidance: Domestic violence and abuse. Available at https://www.gov.uk/domestic-violence-and-abuse, accessed July 20, 2014

[5] Garcia Moreno C, Watts C. Violence against women: an urgent public health priority. Bulletin of the World Health Organization 2011;89:2-2.

[6] Walker, L. E. 1984, The Battered Woman Syndrome, Springer Publishing Company, New York, quoted by Craven Z. Battered woman syndrome. Australian Domestic and family Violence Clearinghouse, 2003, at http://www.adfvc.unsw.edu.au/PDF%20files/battered%20_woman_syndrome.pdf, accessed June 10, 2014

[7] Valdez Santiago M y Ruiz Rodriguez M: Violencia doméstica contra las mujeres: ¿cuándo y cómo surge como problema de salud pública? Salud Publica Mex 2009;51:505-511.

[8] World Health Organization: Addressing violence against women and achieving the Millennium Development Goals. Department of Gender, Women and Health Family and Community Health, 2005. P 9, available at http://www.who.int/gender/documents/MDGs&VAWSept05.pdf, accessed on July23, 2014

[9] Rico N. Gender based violence: a human rights issue. Serie Mujer y Desarrollo, # 16, ECLAC, 1997. At http://www.eclac.org/publicaciones/xml/3/4743/lcl957i.pdf, accessed June 10, 2014

[10] The Universal Declaration of Human Rights, at http://www.un.org/en/documents/udhr/). Accessed June 6, 2012

[11] Organization of American States (OAS). "Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Convention of Belem do Para")". 9 June 1994. accessed August 20, 2013.

[12] The Convention for the Elimination of all the forms of discrimination against women, (CEDAW) available at:(http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx), accessed on May 13, 2013

[13] UN Women: United Nations Entity for Gender Equality and the empowerment of Women, at http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm, accessed on June 10, 2014

[14] General recommendations of the Commission of the Elimination of Discrimination against women. At http://www.un.org/womenwatch/daw/cedaw/cedaw25years/content/english/General_Recommendations_1-25-English.pdf, accessed May 20, 2014

[15] General recommendations op cit.

[16] Women's Resource Center: Summary of CEDAW General recommendations. At http://thewomensresourcecentre.org.uk/wp-content/uploads/2012/12/cedaw_summary_of_general_recommendations.pdf, accessed May 5, 2014

[17] UN 48/104 op cit

[18] Ferrer Perez V, Bosch Fiol E, Riera Madurell V: Las dificultades en la cuantificación de la violencia contra las mujeres en la pareja: análisis psicosocial. Intervención Psicosocial, 2006, Vol. 15 N.° 2 Págs. 181-201 ISSN: 1132-0559

[19] UNICEF (2000). Informe Innocenti. Available at: http://www.unicef-icdc. org/publications/ pdf/digest6s.pdf. accessed on July 20, 2014

[20] Watts C, Zimmermann C.: Violence against women: Global scope magnitude. Lancet 2002; 359; 1232-1237

[21] World Health Organization and Program for Appropriate Technology in Health: Researching violence against women: a practical guide for researchers and activists, 2005

[22] WHO Department of Gender, Women and Health: Putting women first: Ethical and safety recommendations for research on domestic violence against women. 2001

[23] n: WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva, World Health Organization, 2005

[24] Garcia-Moreno C and Watts C.: Violence against women: an urgent public health priority. *Bulletin of the World Health Organization* 2011;89:2-2
[25] Kishor S, Johnson K (2004) Profiling domestic violence: a multi-country study. Calverton, Maryland, USA: MEASURE DHS and ORC Macro. Available at http://measuredhs.com/publications/publication-od31-other-documents.cfm, accessed July 4, 2013
[26] Bott S, Guedes A, Goodwin M, Mendoza JA (2012) Violence Against Women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries. Washington, DC: Pan American Health Organization. Chapter 3, pp19-28.
[27] WHO, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council: Global and regional estimates of violence against women,
Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013, availalble at http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/, accessed on May 7, 2013
[28] Campbell JC. Health consequences of intimiate partner violence. Violence against women II. Lancet 2002; 359: 1331–36.
[29] Campbell J, Jones AS, Dienemann J, Kub J, Schollenberger J, O'Campo P, et al. (2002). Intimate partner violence and physical health consequences. Archives of Internal Medicine. 162(10): 1157-63.)
[30] Dienemann, Jacqueline; Campbell, Jacquelyn; Landenburger, Karen; and Curry, Mary Ann, "The Domestic Violence Survivor Assessment: A Tool for Counseling Women in Intimate Partner Violence Relationships" (2002). Nursing & Healthcare Leadership Publications. Paper 33.
http://digitalcommons.tacoma.uw.edu/nursing_pub/33
[31] Briere J and Jordan C: Violence Against Women Outcome Complexity and Implications for Assessment and Treatment. JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 19 No. 11, November 2004 1252-1276
[32] Mechanic M, Weaver T, Resick P: Risk Factors for Physical Injury Among Help-Seeking Battered Women: An Exploration of Multiple Abuse Dimensions. Violence Against Women. 2008 October ; 14(10): 1148–1165.
[33] Heise L: Violence against women: The hidden health burden. World Bank Discussion Papers 255, World Bank 1994
[34] Mechanic M, Weaver T, Resick P. :Mental Health Consequences of Intimate partner abuse.Violence Against Women. Jun 2008; 14(6): 634–654.
[35] Maman S, Campbell JC, Sweat M, Gielen AC. The intersection of HIV and violence: directions for future research and interventions. Soc Sci Med 2000; 50: 459–78.
[36] McFarlane A. The long-term costs of traumatic stress: intertwined physical and psychological consequences. World Psychiatry 2010;9:3-10)
[37] Inslicht SS, Marmar CR, Neylan TC, et al. Increased cortisol in women with intimate partner violence-related post-traumatic stress disorder. Psychoneuroendocrinology. 2006;31: 825–838
[38] Sutherland C, Bybee D, Sullivan C. Beyond bruises and broken bones: The joint effects of stress and injuries on battered women's health. American Journal of Community Psychology 2002;30:609–636.
[39] Nathanson, Alison M.; Shorey, Ryan C.; Tirone, Vanessa; Rhatigan, Deborah L. The Prevalence of Mental Health Disorders in a Community Sample of Female Victims of Intimate Partner Violence. Partner Abuse, Volume 3, Number 1, January 2012 , pp. 59-75

[40] Bott S, Guedes A, Goodwin M, Mendoza JA (2012) Violence Against Women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries. Washington, DC: Pan American Health Organization, p XVII
[41] Golding J. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. J Fam Violence 1999;14: 99-132
[42] Nolen- Hoeksema S. Epidemiology and theories of gender differences in unipolar depression IN: Seeman, MV Editor. Gender and Psychopathology. APPI, Washington DC, 1995. P 80
[43] Beydoun h, Ahl-Sahab B. Beydoun M, Tamim H: Intimate Partner Violence as a Risk Factor for Postpartum Depression among Canadian Women in the Maternity Experience Survey. Ann Epidemiol 2010;20:575–583.
[44]Kantor GK, Asdigian N. When women are under the influence. Does drinking or drug use by women provoke beatings by men? Recent Developments in Alcoholism. 1997;13:315–336.
[45] Nixon R.D.V., Resnick P.A., Nishith P. An exploration of comorbid depression among female victims of intimate partner violence with posttraumatic stress disorder (2004) Journal of Affective Disorders, 82 (2) , pp.315-320.
[46] Street AE, Arias I: Psychological abuse and posttraumatic stress disorder in battered women: examining the roles of shame and guilt. Violence Vict 2001, 16:65-78
[47] Beydoun HA, Beydoun MA, Kaufman JS, Lo B, Zonderman AB. Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: a systematic review and meta-analysis. Soc Sci Med. 2012 Sep;75(6):959-75

[48] Testa M, Kubiak A, Quigley BM, Houston RJ, Derrick JL, Levitt A, Homish GG, Leonard KE. Husband and wife alcohol use as independent or interactive predictors of intimate partner violence. J Stud Alcohol Drugs. 2012 Mar;73(2):268-76.
[49] WHO 2013, p27
[50] Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L.B., Deyessa, N.,Heise, L., Durand, J., Mbwambo, J., Janssen, H., Berhane, Y., Ellsberg, M., Garcia-Moreno, C. Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. Soc Sci Med. 2011 Jul;73(1):79-86
[51] WHO 2013, p16
[52] .Kishor S, Johnson K (2004) Profiling domestic violence: a multi-country study. Calverton, Maryland, USA: MEASURE DHS and ORC Macro. Available at http://measuredhs.com/publications/publication-od31-other-documents.cfm, accessed July 4, 2013
[53] Bott S, Guedes A, Goodwin M, Mendoza JA (2012) Violence Against Women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries. Washington, DC: Pan American Health Organization)
[54] Han A, Stewart DE. Maternal and fetal outcomes of intimate partner violence associated with pregnancy in the Latin American and Caribbean region. Int J Gynaecol Obstet. 2014 Jan;124(1):6-11. doi: 10.1016/j.ijgo.2013.06.037. Epub 2013 Oct 5
[55] Bott 2012, p 55
[56] Devries 2011
[57] Garcia-Moreno C, Jansen H, Ellsberg M, Heise L, Watts C (2005) WHO multi-country study on women's health and domestic violence against women. Geneva: World Health Organization
[58] Organización Mundial de la salud: Estudio multi país sobre salud de la mujer y violencia contra la mujer. Hallazgos por país: Perú. OMS 2005,at:
http://www.who.int/gender/violence/who_multicountry_study/fact_sheets/per/es/index.html, accessed August 13, 2011)
[59] Bott 2012, p 12
[60] Diaz R, Miranda JJ. Aproximación del costo económico y determinantes de la violencia doméstica en el Peru. Instituto de Estudios Peruanos y Cento de Investigacion Económica y Social, CIES 2010 pp 82, at http://www.old.cies.org.pe/files/documents/investigaciones/genero/aproximacion-del-costo-economico-y-determinantes-de-la-violencia-domestica-en-el-peru.pdf, accessed October 7. 2013
[61] Bardales, O. (2012). Estado de las investigaciones en violencia familiar y sexual 2006 - 2010. MIMP, Lima.P 23
[62] Escobar-Montalvo J. violencia basada en género y depresión postparto en el Hospital San Bartolomé, Lima Perú, IN: Bardales, O. (2012). Estado de las investigaciones en violencia familiar y sexual 2006 - 2010. MIMP, Lima. P 104
[63] Reynaga G. respuesta de las mujeres ayacuchanas frente a os problemas de la violencia política. 2008 UNSM In: Bardales, O. (2012). Estado de las investigaciones en violencia familiar y sexual 2006 - 2010. MIMP, Lima. P 126
[64] Lecca Silva N. Indicadores emocionales del psicodiagnostico de Rorschach en un grupo de adolescentes víctimas de violencia sexual. 2009 PUCP In: Bardales, O. (2012). Estado de las investigaciones en violencia familiar y sexual 2006 - 2010. MIMP, Lima. P 121
[65]Zorosabal de la Cruz F. Violencia Psicológica y disfunción sexual de la mujer. UNMSM In: Bardales, O. (2012). Estado de las investigaciones en violencia familiar y sexual 2006 - 2010. MIMP, Lima. P 101
[66] Bott 2012, p 30
[67] Defensoría del Pueblo del Perú. Derecho a la salud de las mujeres víctimas de violencia: supervisión a establecimientos de salud de Lima y Callao, Serie Informes de Adjuntía, Informe 003-2010-DP-ADM)

[68] DPP, op cit . p 49
[69] Bott, S., Morrisson, A. and Ellsberg, M. 2005. “Addressing Violence against Women in Middle and Low-Income Countries: A Multi-Sectoral Approach.” Washington, DC.: World Bank.
http://siteresources.worldbank.org/INTGENDER/Resources/MultiSector.pdf. Accessed July 26, 2014
[70] Betron, Myra and Lucía Fort. 2006. "Mainstreaming Gender in the Health Sector: Prevention of GBV and Male involvement in Reproductive Health." En Breve, 88.
http://siteresources.worldbank.org/INTENBREVE/Newsletters/20946627/88-APR06-Gender.pdf, accessed on July 26, 2014
[71] UN Women: Key theoretical models for building a comprehensive approach, available at
http://www.endvawnow.org/en/articles/647-key-theoretical-models-for-building-a-comprehensive-approach.html accessed August 20, 2014
[72] Decker M; Frataroli S; McCaw B, Coker A, Miller E et al: Transforming the Healthcare Response to Intimate Partner Violence and Taking Best Practices to Scale. JOURNAL OF WOMEN’S HEALTH 2012, 21, 1222-1229
[73] Morrison, A, Mary Ellsberg and Sarah Bott. 2004. “Addressing Gender-Based Violence in the Latin American and Caribbean Region: A Critical Review of Interventions.” World Bank Policy Research Working Paper 3438,

Washington, D.C, at http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2004/11/05/000160016_20041105120943/Rendered/PDF/wps3438.pdf, accessed July 30, 2014

[74] Colombini M, Mayhew S, Watts C.: Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities. Bulletin of the World Health Organization 2008;86:635–642.

[75] Garcia Moreno C.: Dilemmas and opportunities for an appropriate health service response to violence against women. Lancet 2002; 359: 1509–14

[76] Colombini, op cit

[77] Colombini M, Mayhew S, Ali S, Shuib R, Watts C.: An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up. BMC Public Health 2012, 12:548

[78] Abramski T, Devries K; Kiss L; Francisco L, Nakuti J et al A community mobilisation intervention to prevent violence against women and reduce HIV/AIDS risk in Kampala, Uganda (the SASA! Study): study protocol for a cluster randomised controlled trial. Trials 2012, 13:96

[79] Keesbury J. and Askew I. 2010. Comprehensive responses to gender based violence in low-resource settings: Lessons learned from implementation. Population Council. Lusaka, Zambia.

[80] Keesbury and Askew, op cit. p 23 and ff

[81] OAS 1994, op cit

[82] CEDAW op cit

[83] General recommendations, op cit

[84] Ley General de Salud, 26842 y concordancias. Ministerio de Salud del Peru, at ftp://ftp.minsa.gob.pe/intranet/leyes/L-26842_LGS.pdf, a ccessed May 5, 2013

[85] Ministerio de Justicia del Peru:, Ley 26260 Ley de Proteccion frente a la Violencia familiar, Texto Unico Ordenado at http://www.mimp.gob.pe/files/direcciones/dgcvg/legisnacional/ley26260.pdf, accessed May 13, 2013

[86]Ministerio de la Mujer y Poblaciones Vulnerables (MIMP). Plan Nacional contra la Violencia hacia la Mujer 2009-2015, at http://www.mimp.gob.pe/files/programas_nacionales/pncvfs/planes/plan-nacional-contra-violencia-mujer-2009-2015.pdf, accessed Jun 10, 2013

[87] Bott S, Guedes A, Claramunt MC, Guezmes A: PAHO's Improving the Health Sector Response to Gender Based Violence, A Resource manual for Health Professionals in Developing Countries. IPPF/WHR 2010, available at http://www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf, retrieved August 10, 2012

[88] Bott, 2010, p 39

[89] Bott 2010 p 40

[90] Organización Panamericana de la Salud. Componentes clave en la formulación de leyes y políticas contra la violencia hacia las mujeres. Documento de discusion. Washington:OPS; 2003. Quoted by Ortiz Barreda 2013

[91] United Nations Department of Economic and Social Affairs, Division for the Advancement of Women. Handbook for Legislation on Violence against Women. DESA, Washington, 2009. At http://www.un.org/womenwatch/daw/vaw/handbook/Handbook%20for%20legislation%20on%20violence%20against%20women.pdf, accessed on May 5, 2014

[92] Yamin A, Rios M. Derechos humanos y Salud: Vinculando dos perspectivas. Asociación Pro Deerechos Humanos, Centro de la Mujer Peruana Flora Tristan y Consorcio de Investigaciones Económicas y Sociales, Lima 2002 at http://old.cies.org.pe/files/documents/otras-inv/derechos-humanos-y-salud-vinculando-dos-perspectivas.pdf. Accessed May 5 2014.

[93] Hurtado R y Rios M.: Peru: Balance sobre la situación de salud. At: http://www.bvsde.paho.org/bvsacd/cd53/dersal/cap10.pdf, accessed May 20, 2014

[94] Bott 2002, p 3

[95] Bott, op cit, p 40

[96] Jewkes R. Intimate partner violence: causes and prevention. Lancet 2002; 359: 1423–29

[97] World Health Organization: Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. 2013 at http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf?ua=1, accessed on June 26, 2013, p 16-18

[98] G Feder, J Ramsay, D Dunne, M Rose, C Arsene, R Norman, S Kuntze, A Spencer, L Bacchus, G Hague, A Warburton, and A Taket. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. Health Technol Assess. 2009 Mar;13(16):iii-iv, xi-xiii, 1-113, 137-347

[99] Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. BMJ. 2002 Aug 10; 325(7359):314.

[100] MacMillan HL1, Wathen CN, Jamieson E, Boyle MH, Shannon HS, Ford-Gilboe M, Worster A, Lent B, Coben JH, Campbell JC, McNutt LA; McMaster Violence Against Women Research Group: Screening for intimate partner violence in health care settings: a randomized trial. JAMA. 2009 Aug 5;302(5):493-501.
[101] Garcia Moreno C. Dilemmas and opportunities for an appropriate health system response to violence against women. Lancet 2002;359:1509-14.
[102] WHO, 2013 p 13
[103] WHO, 2013, p 3
[104] WHO 2013, op cit p 25
[105] Ivbijaro G, Funk M. No mental health without primary care. Mental Health in Family Medicine 2008;5:127–8
[106] Patel V, Thornicroft G (2009) Packages of Care for Mental, Neurological, and Substance Use Disorders in Low- and Middle-Income Countries: PLoS Medicine Series. PLoS Med 6(10): e1000160. doi:10.1371/journal.pmed.1000160
[107] Organización Panamericana de la salud. Declaración de Caracas. 14 de Noviembre de 1990. Adoptada por aclamación en Conferencia Reestructuración De la Atención Psiquiátrica en América Latina. Caracas, Venezuela. At: www.oas.org/dil/esp/Declaracion_de_Caracas.pdf. Accessed June 10, 2012
[108] WHO. Organization of Services for Mental Health. Mental Health Policy and Service Guidance Package. Geneva, 2008, p 5
[109] WONCA
[110] ORTIZ-BARREDA, Gaby and VIVES-CASES, Carmen. Legislation on violence against women: overview of key components. Rev Panam Salud Publica [online]. 2013, vol.33, n.1 [cited 2014-06-15], pp. 61-72 . Available from: <http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1020-49892013000100009&lng=en&nrm=iso>. ISSN 1020-4989. http://dx.doi.org/10.1590/S1020-49892013000100009
[111] Jewkes 2002, op cit
[112] Defensoría del Pueblo, Adjuntía para los derechos de la mujer. Derecho a la salud de las mujeres víctimas de violencia: supervisión de establecimientos en Arequipa, Junín, Lima, Piura y Puno. Informe de Adjuntía 0003/2012, p 80
[113] Kaysen D, Morris M, Rizvi S, Resick P:PERITRAUMATIC RESPONSES AND THEIR RELATIONSHIP To PERCEPTIONS OF THREAT IN FEMALE CRIME VICTIMS. Violence Against Women. 2005 December ; 11(12): 1515–1535.
[114] Ministerio de Salud y Organización Panamericana de la Salud: Informes sobre los Servicios del Sub Sector Ministerio de Salud del Peru, 2008. Minsa 2009, p 15. At http://www.who.int/mental_health/mhgap/evidence/mh_who_aims_peru_apr2010_en.pdf?ua=1. Accessed April 27, 2014
[115] Institute of Medicine. Clinical Practice Guidelines: Directions for a New Program. Washington, DC: The National Academies Press, 1990. Quoted by Eccles et al. Implementation Science 2012, 7:60
[116] Cutipe, Y, Director Mental Health, Minsa, personal communication

[117] *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010